INSURANCE PROTECTION FOR CATASTROPHIC HEALTH EXPENSES FOR INDIVIDUALS UNDER AGE 65

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

MAY 12, 1987

Serial 100–37

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

82-404 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H781-27

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida
J.J. PICKLE, Texas
CHARLES B. RANGEL, New York
FORTNEY H. (PETE) STARK, California
ANDY JACOBS, JR., Indiana
HAROLD FORD, Tennessee
ED JENKINS, Georgia
RICHARD A. GEPHARDT, Missouri
THOMAS J. DOWNEY, New York
FRANK J. GUARINI, New Jersey
MARTY RUSSO, Illinois
DON J. PEASE, Ohio
ROBERT T. MATSUI, California
BERYL ANTHONY, JR., Arkansas
RONNIE G. FLIPPO, Alabama
BYRON L. DORGAN, North Dakota
BARBARA B. KENNELLY, Connecticut
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
MICHAEL A. ANDREWS, Texas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin

JOHN J. DUNCAN, Tennessee
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
DICK SCHULZE, Pennsylvania
BILL GRADISON, Ohio
WILLIAM M. THOMAS, California
RAYMOND J. McGRATH, New York
HAL DAUB, Nebraska
JUDD GREGG, New Hampshire
HANK BROWN, Colorado
ROD CHANDLER, Washington

ROBERT J. LEONARD, *Chief Counsel*
M. KENNETH BOWLER, *Staff Director*
A.L. SINGLETON, *Minority Chief of Staff*

SUBCOMMITTEE ON HEALTH

FORTNEY H. (PETE) STARK, California, *Chairman*

BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
J.J. PICKLE, Texas
BERYL ANTHONY, JR., Arkansas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin

BILL GRADISON, Ohio
HAL DAUB, Nebraska
JUDD GREGG, New Hampshire
ROD CHANDLER, Washington

CONTENTS

Page

Press release of Tuesday, May 5, 1987, announcing the hearing 2

WITNESSES

American Airlines, Inc., Robert L. Crandall and Delores Wallace 5
Children's Defense Fund, Sara Rosenbaum 15
National Association of Children's Hospitals and Related Institutions, Robert H. Sweeney presenting statement of J.E. Stibbards 32
United States Chamber of Commerce, Robert E. Patricelli and James A. Klein 59

SUBMISSIONS FOR THE RECORD

American Chiropractic Association, W. Randall Rawson, statement and attachment 81
American Medical Association, James H. Sammons, M.D., letter and attachment 84
ERISA Industry Committee, statement 88
Select Committee on Children, Youth, and Families, U.S. House of Representatives, Hon. George Miller, Chairman, a Representative in Congress from the State of California, statement and attachments 93

INSURANCE PROTECTION FOR CATASTROPHIC HEALTH EXPENSES FOR INDIVIDUALS UNDER AGE 65

TUESDAY, MAY 12, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 1100, Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, MAY 5, 1987

PRESS RELEASE #13
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON
INSURANCE PROTECTION FOR CATASTROPHIC HEALTH EXPENSES
FOR INDIVIDUALS UNDER AGE 65
TO BE HELD ON TUESDAY, MAY 12, 1987

The Honorable Fortney H. (Pete) Stark (D. Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will conduct a hearing on insurance protection for catastrophic health expenses for those under age 65. The hearing will be held on Tuesday, May 12, 1987, beginning at 10:00 a.m., in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "A significant and growing number of Americans do not have financial access to necessary health services and are at risk for catastrophic expenses. More than two-thirds of these individuals, or their dependents, are employed. It is essential that we explore approaches to assuring basic health benefits to each of our citizens."

The purpose of the Subcommittee hearing is to obtain information concerning the nature and extent of this problem and to examine possible solutions. Representatives of labor, management, and the health insurance industry will have an opportunity to present information on alternative responses to the problem of lack of health insurance coverage.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

In 1985, 17.4 percent of the civilian nonagricultural population under age 65 reported no health insurance coverage from any source. This group totalled more than 35 million persons. The proportion of the nonelderly population without health insurance coverage has grown since 1982, when 15.5 percent of the population were uninsured.

In 1985, more than half of the uninsured, or 19 million people, were workers. Another one-third, or 11 million people, were children, age 18 or under. Only 13 precent of the uninsured were nonworking adults.

In addition to the uninsured, many Americans are underinsured. Almost 40 percent of the under age-65 population have no out-of-pocket limit for both hospital and medical expenses. Survey results indicate that uninsured families are significantly less likely to receive needed medical attention than insured families. Uninsured persons also are twice as likely to be without a regular source of health care than insured persons.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, June 5, 1987 to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C., 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

*****

Chairman STARK. The Subcommittee on Health of the Committee on Ways and Means will commence its hearing on catastrophic coverage for the population under age 65 who do not qualify for Medicare.

The hearing will focus on the question mandating health care benefits for the uninsured as well as the insured.

In 1986, there were an estimated 37 million Americans without health insurance and another 7 to 10 million Americans with partial coverage for a portion of the year.

There is no such thing as a noncatastrophic encounter with the health care delivery system when a family is poor and has no health insurance.

From all signs, the number of uninsured is growing. Almost 16 percent of the nonfarm population were not covered in 1982, a year in which the economy was in recession. Almost 18 percent were not covered in 1985, a stronger year economically.

What is startling is that 19 million of the uninsured, or 55 percent are employed, and almost 70 percent of this population live in families of full-time, full-year workers. For most of these families, the family heads have never experienced unemployment.

A particular problem is lack of insurance for children. Almost 20 percent of children under age 16 are not covered. Clearly these children face a catastrophic expense every time they need basic health care services.

Lack of catastrophic coverage is a problem that faces many Americans. This lack of coverage for a significant portion of the uninsured population is a serious concern and one that needs to be addressed.

Mr. Gradison has proposed legislation to resolve this problem, and I am pleased to join with him in supporting it.

I hope our witnesses today will help the subcommittee define the problem and suggest ways in which health care for the uninsured can be addressed. I look forward to their testimony.

As is the custom in the subcommittee, we will ask the witnesses to summarize or expand on their prepared testimony, giving the committee some more time to enter into a dialogue as we inquire.

I would like to recognize Mr. Gradison at this time.

Mr. GRADISON. Thank you, Mr. Chairman.

I am delighted that this hearing could be scheduled to give the subcommittee the opportunity to hear testimony on this subject of extending the catastrophic protection which we are now working on for the elderly to those who are not yet eligible for Medicare.

It seems to me, Mr. Chairman, that it would be a lost opportunity if this year the only action which we took on the catastrophic issue applied to the elderly. Certainly the problems of other age groups are very much the same.

I had hoped that it would be possible to have a bill ready to include in the catastrophic measure which the full committee approved last week, that would cover those under 65 who are currently covered by private health insurance plans. Unfortunately, it was not possible to have the bill ready at that time. But we may have an opportunity to develop an appropriate vehicle to cover this population as part of the reconciliation language which we will be called upon to furnish in connection with the budget.

I particularly want to thank you, Mr. Chairman, for joining with me in the introduction of H.R. 2300, and I look forward to gaining the insights of the witnesses who will appear before us this morning.

Chairman STARK. Our first witness this morning is Mr. Robert L. Crandall, chairman and President of American Airlines.

Mr. Crandall, it is a pleasure to have you appear before us this morning, and I hope that you will proceed to enlighten us in any manner you are comfortable.

STATEMENT OF ROBERT L. CRANDALL, CHAIRMAN OF THE BOARD AND PRESIDENT, AMERICAN AIRLINES, INC., ACCOMPANIED BY DELORES WALLACE, VICE PRESIDENT OF PERSONNEL

Mr. CRANDALL. Thank you, Mr. Chairman.

I appreciate the invitation to testify. I have with me Delores Wallace, our vice president of personnel, who will join me in responding to any questions that you and the other members of the subcommittee may have.

We are glad to be here this morning because we believe it's time for American business to take a fresh look at the costs and the equities of health care for employees. And my purpose in being here is to encourage the committee to enact legislation that will require employers to provide health benefits for all employees and for retirees.

I am convinced, considering the alternatives, that other businesses will soon join us in supporting such legislation, and I would like to tell you why.

As you pointed out, our current system has left millions of Americans without any health care coverage whatsoever, and many millions more inadequately covered. And as you have also pointed out, that can be a very real tragedy for any family.

If for no other reason, I think we ought to have a goal of universal health care coverage because it is the right thing to do. There is, in addition, a more pragmatic side of that issue. I would argue that for most U.S. firms, a policy of mandatory health benefits would be simply good business. Let me say why.

Everyone, I think, knows there is no such thing as a free lunch. In fact, being in the airline business, I can assure you there is no such thing as even a free bag of peanuts. Companies that believe they are avoiding health care costs by not offering employee retirement benefits are simply wrong. They, like the rest of us, are paying in one way or another for the health care costs of the roughly 37 million Americans who do not have insurance. Unfortunately, those employers that do not provide coverage for their employees probably are managing to avoid paying their fair share.

And that leads us to the problem, which is that companies like our own pay twice, once for their own employees, and then again, by means of taxes and inflated health insurance premiums for the employees of those businesses who do not provide benefits.

While many millions of Americans don't have health care insurance, only a very few actually go without health care. Some of the

uninsured pay their own way, but the majority, on the other hand, rely either on public health programs or charitable services.

Now, I want to be very clear about the fact that America has no objection to paying its fair share of the health care costs of low income individuals and senior citizens. We do, on the other hand, object to paying for the health care costs of individuals who are employed by or retired from other businesses, some of whom may even be our competitors. And that is what's happening today and, in my view, it is inequitable to allow some businesses to shift those costs to others. Indeed, I think there is some possibility that we may be seeing the start of a very unhappy trend by which employers will avoid providing health care benefits as a means of gaining competitive advantage, and that has already happened in the airline business. In fact, I think that is one of the factors accounting for the much discussed decline in the airline service standards.

Let me offer, if I can, one concrete example of how this problem is going to get worse if we don't take appropriate action.

Some years ago, Continental Airlines declared bankruptcy. As a byproduct of that, it abrogated its labor contracts and it eliminated, among many other benefits, medical benefits for its retirees. From a business perspective, that bankruptcy was an extraordinary success. Continental has since emerged from bankruptcy, and its parent company, Texas Air, is now the Nation's largest airline company.

From a public perspective, however, it is a different question. As a result of that bankruptcy, Continental's labor costs, which encompass both their wage and benefit costs, are now about one-half those of other airlines.

Now, you do not have to be a business genius to figure out that when a company has labor costs which are twice those of a larger competitor, something somewhere along the way is going to give.

Consider the question of medical coverage for retirees as a single example. I have included in my written testimony a chart that shows that in less than 10 years time, American Airlines' costs for retiree health insurance is going to be more than $120 million annually. Continental doesn't provide medical benefits for retirees. Thus, unless something changes, we will have to collect about $10 million a month more from our passengers than they will from their, and that is only about 20 percent of the problem.

On an overall basis, their labor cost advantage amounts to something like $600 million a year, or about $50 million a month.

Now, in the airline business, costs really don't vary much from one company to another. There isn't much to this whole notion of no frills. We all pay about the same thing for fuel and equipment and food and interest rates and so on. There is one significant difference between carriers, and that is their labor costs. And if we have to turn around and cut our labor cost and benefits costs to match those of Continental, we and our employees have got some very painful times ahead.

In my own view, permitting companies to skimp on employee and retiree benefits, things like pensions and adequate medical insurance is simply not sound public policy. And if that should represent the beginning of a trend, our Nation is in very deep trouble. And it is my view that now is the time to put a stop to it.

I think we also need to recognize that when an employer has a stake in the health of its employees, it is much more inclined to provide a working atmosphere that encourages fitness and good health. If every company pays its fair share of health costs, I am inclined to think that workplace health programs will expand and that the Nation's total health care costs will decline.

In the course of these remarks, I have referred to both employee and retiree benefits. I should like to make a special appeal, that you include retiree health care benefits explicitly in whatever package you put together. In my opinion, every company ought to provide a full range of retiree benefits and no company ought to be allowed to withdraw benefits already promised to retirees. Retirement ought to be a time of reduced anxiety and uncertainty, and it seems to me nothing short of outrageous that companies might withhold or withdraw benefits from those most in need.

To summarize, legislation prescribing mandatory employer paid health benefits for employees and retirees will accomplish what I think are four important objectives. First, it will serve to keep responsibility to health care in the private sector where it can be administered on the most cost effective basis.

Second, it will provide a more equitable distribution of health care costs.

Third, it will eliminate the practice of reducing benefits for competitive reasons.

And, finally, in my opinion, it will ultimately lower total health care costs as more employers attach importance to maintaining the good health of their employees.

Mr. Chairman, Ms. Wallace and I will be happy to respond to any questions you may have.

[The prepared statement follows:]

Statement of Robert L. Crandall
Chairman and President
American Airlines, Inc.

Before the
Health Subcommittee of the
Committee on Ways and Means

May 12, 1987

My name is Robert L. Crandall. I am Chairman and President of American Airlines. I welcome this opportunity to testify because I believe it is time for American business to take a fresh look at the costs and equities of health care for employees.

I am here to encourage the Committee to enact legislation that will require employers to provide basic health benefits for all employees and retirees. I am convinced -- considering the alternatives -- that other businesses will soon join us in supporting such legislation. Let me tell you why.

Our current voluntary system has left millions of Americans without any health coverage whatsoever, and millions more inadequately covered. Unforeseen health care expenditures -- even ones that normally aren't classified as catastrophic -- can have a devastating impact on the economic well-being of families. Health care insurance can prevent families from having a health tragedy compounded by economic ruin -- and everyone needs that protection.

If for no other reason, we should have a goal of universal health care coverage because it is the right thing to do. There is, of course, a more pragmatic side of the issue. I would argue that for most U.S. firms, a policy of mandatory health benefits would be good business. Let me explain why.

Everyone knows that there is no such thing as a free lunch. In fact, being in the airline business, I can assure you that there is not even such a thing as a free bag of peanuts. Companies that believe they are avoiding health care costs by not offering employee or retiree benefits are simply wrong. They, like the rest of us, are in fact paying -- in one way or another -- for the health care costs of the roughly 37 million Americans who are without insurance. Unfortunately, those employers that do not offer their employees coverage probably are avoiding paying their fair share.

That leads us to the problem, which is that companies like ours pay twice -- once for our own employees and then again, via taxes and inflated health insurance premiums -- for the employees of those businesses who don't provide benefits for their own people.

While tens of millions of Americans do not have health care insurance, only a very few actually go without health care. Some of the uninsured pay their own way, but the majority rely either on public health programs or charitable services.

Let me make it clear that American Airlines does not object to paying its fair share of the health care costs

of low income individuals and senior citizens. But we do object to paying for the health care costs of individuals employed by or retired from other businesses, some of whom may even be our competitors. And that is precisely what is happening today. It is absolutely inequitable to allow some businesses to shift these costs to others.

Indeed, I fear that we may be seeing the start of an unhappy trend by which employers will avoid providing health care benefits as a means of obtaining advantages over their competitors. It has already happened in the airline industry. In fact, I think this is one of many factors accounting for the much discussed decline in the service standards of our industry.

Let me give you one concrete example of how this problem will get worse if we don't take appropriate action. When Continental Airlines declared bankruptcy a few years ago, it abrogated its labor contracts and eliminated, among other benefits, medical benefits for many of its retirees. From a business perspective, the bankruptcy was an extraordinary success. Continental has since emerged from bankruptcy and its parent -- Texas Air -- is now the nation's largest airline company. But from a public point of view, it is a different question. As a result of the bankruptcy, Continental's labor costs are now about half those of many other airlines.

You don't have to be a business genius to figure out that when a company has labor costs twice that of a larger competitor, something has to give. Consider the question of medical coverage for retirees as a single example. I have included a chart in my testimony that shows that in less than 10 years American's costs for retiree medical coverage will be over $120 million annually. Continental does not provide medical benefits for retirees. Thus, unless something changes, we'll have to collect $10 million a month more from our passengers than Continental Airlines does -- and that's only about 20% of the problem. Overall, Continental's wage and benefit costs give it an annual advantage of more than $600 million a year -- or about $50 million a month.

In the airline business most costs do not vary much from one company to another. There really isn't much to the "no frills" idea; we all pay about the same for fuel, equipment, food, interest rates, and so on. The only significant difference between carriers is their respective labor costs and if we must cut our labor costs to match Continental, we and our employees have some painful times ahead.

In my view, permitting companies to scrimp on employee and retiree benefits like fair pensions and adequate medical insurance is simply not sound public policy. If this is the beginning of a trend, our nation is in deep trouble -- and now is the time to put a stop to it.

Our current international trade problems have made us all particularly sensitive to competition from Japan; among other characteristics of Japan's industrial strength is the commitment of its businesses to the basic needs of workers. There is something here we can learn from the Japanese -- a decent regard for the health of our nation's workers is both good business sense and good public policy.

We should also recognize that when an employer has a stake in the health of its employees, it is much more inclined to provide a working atmosphere that encourages fitness and good health. Progressive companies in America work with their employees to reduce illness and accidents -- not only because it is the right thing to do, but also because it is cost-effective. That incentive is substantially less if employers have no direct financial stake in the cost of health care. If every company pays its fair share of health costs, I believe that workplace health programs will expand and that the nation's total health care costs will fall.

Throughout these remarks, I have referred to both employee and retiree benefits. I want to make a special appeal that you include retiree health care benefits in whatever package you put together. In my view, every company ought to provide a full range of retiree benefits and no company should be allowed to withdraw benefits already promised to retirees. Retirement should be a time of reduced anxiety and uncertainty. It is nothing less than outrageous to withhold or withdraw benefits from those most in need of them.

In summary, legislation prescribing mandatory employer-paid health benefits for employees and retirees will accomplish four important objectives: First, it will serve to keep responsibility for health care in the private sector, where it can be administered on the most cost effective basis. Second, it will provide a more equitable distribution of health care costs. Third, it will eliminate the practice of reducing benefits for competitive reasons. Fourth, it will ultimately lower total health care costs as more employers attach importance to maintaining the good health of their employees.

Chairman STARK. Mr. Crandall, thank you. It is always reassuring to find that great minds go in the same direction.

And if I have said once since becoming Chair of this subcommittee, I guess I have said a dozen times, and paraphrased your opening statement, that we are providing medical care for better or for worse for all but probably 5 or 6 million Americans, and you are picking up the extra costs for the uninsured or indigent in real estate taxes, higher hospital bills and higher medical insurance bills. If it is postponed medical care, you are paying for it in the outyears where we do not get budget scoring; if it is lack of prenatal care and gynecological and pediatric care, we pay for it in more severe illnesses in later years.

We are not a country that rations medical services, so somehow it gets paid for. I suspect that your concern is to do two things. Distribute the service a little more efficiently, if everybody can pay and determine how to fairly distribute the costs.

Is that a fair statement?

Mr. CRANDALL. I think that's a very fair summation, Mr. Chairman.

As I say, in my own summary of the benefits of such legislation, I do think that from our own experience that two things happen when an employer provides a comprehensive package of benefits. One is that we become very concerned about the efficient delivery of those benefits. And I believe that the work we have done and that many other employers have done in trying to find more efficient delivery methods, preferred providers and HMOs and so forth, stems from the fact that we have a very real financial interest in being certain that the coverage we are paying for is delivered efficiently.

And, second, I think it is not appropriate to distribute the burdens unfairly. I think we are not going to allow people to go without medical care in this country, nor do I think we should. On the other hand, I think that is not an appropriate way to try and establish competitive advantage as between companies seeking a position in the marketplace.

Chairman STARK. Let me just summarize with you a little bit, the kind of procedural dilemma we are in.

As you know, the Federal Government has virtually no regulatory authority over any insurance companies at this point. Our regulatory approach examines benefits, and employee benefits are divided among labor committees and tax committees, so we are kind of spread about.

We found, through our experience last year, that we can encourage businesses to do what we think is the right thing by talking to them through the Tax Code. That tends to get their attention, and we can, by indirection and through the code, require certain minimum benefits for those people who provide health insurance at all. If they don't provide any health or medical insurance, we can't deny the deductibility of something they don't care about.

So I would like to set aside for a moment the easy part of the job, the companies, such as yours, who do the right thing, provide a decent selection of benefits for their employees or negotiate in good faith, if they are with bargaining units, to provide them. That's the easy job.

The tough part is to keep your costs competitive. What do we do with those small businesses who are too small to be economic? There we have got a little bit bigger problem because, looking at the financing, if we do a head tax in effect or a premium tax, then we are only coming after the people with insured or self-insured plans, and the 30-year 20 million with no insurance get out of the box.

If we go on the payroll tax and make the Government the insurer of last resort, you may pay an unfair amount.

We have started to encourage the States to do risk pools, first of all, on those uninsurable—the diabetic, the epileptic—the person who is just absolutely uninsurable. A very small number of people, about 11 States, do that successfully and with a minimum amount of complaint. Taking the next step, the people who can't get it efficiently, is going to be tough, but I think we can do that.

The real question is how do we pay for it? We can go to, as I say, the premium or head tax or so much a month from those who have a program. We could go to a payroll tax. We could go to increasing the minimum wage by virtue of not raising the wage by a dollar, but say we put in a minimum benefit standard which would have the effect of raising the minimum wage. But for you there wouldn't be one because presumably your plan would meet the minimum standard.

What is the most attractive way for you to spread that?

Mr. CRANDALL. Of those approaches, Mr. Chairman, I would—and let me hasten to say that you are a far better judge of method than I—but in a conceptual sense, I would personally favor a statutory minimum benefit package.

It seems to me that the very direct method, rather than the use of the Tax Code, would be to simply establish a minimum benefit package very much like the minimum wage, which says that one of the prices of being in business in this country is that you must provide this.

Moreover, I believe that the private markets, that the mechanisms would deal very nicely with that. In our own case, for example, and in the case of other major companies, there isn't any insurance element to our program. We are self-insured. In effect, we hire insurance companies to administer the plan for us.

In an environment characterized by a minimum benefit package, I think the insurance industry would quickly come forward with mechanisms which would create pools from which would essentially represent for many small businesses the equivalent of the self-insurance pool that our own employees constitute for us.

It seems to me that that is the most direct way and, in addition, the way which does the most to keep the program firmly in the private sector. And that is an objective that I think is very important because now you have got all of the competitive mechanisms that are out there today which we are working hard to harness, and I think as more and more private plans and private providers come into this business, you will find a lot more pressure to find more and more effective delivery systems.

Chairman STARK. Well, I think you are right. We have to convince the business community that this would be effective and economic.

I think we have a precedent in the workmen's compensation, and that is the one problem we still have to address. We can mandate a minimum benefit, but what do we do then to the small employer who can't buy it, for whatever reason? He may have an elderly work force. He may have a work force with some preexisting conditions that are uninsurable.

Don't we then have to either mandate the States to have a pool as we do in workmen's compensation or have some other form to allow that relief valve and find a way to pay for that? That is the only problem that I see. And if we followed the pattern of workmen's compensation, would you have any objection to that as an alternative?

Mr. CRANDALL. I would have no objection to that with the proviso that, in our own cast for example, as the workmen's compensation mechanism has emerged over the years, once again we find ourselves paying premiums for coverage that we could provide more effectively ourselves. And I would hope that the various committees and people who work on this would try to avoid that dilemma, that we wouldn't end up paying twice.

Chairman STARK. If you could provide the benefits, you would stay out of the pools?

Mr. CRANDALL. Yes.

Chairman STARK. I see the pool only as the relief valve for those who would be put out of business because they can't provide a mandated minimum benefit.

Mr. CRANDALL. Mr. Chairman, I think that is something you certainly have got to worry about, think about. And my own belief is that the market is very flexible and will provide those tools. You no doubt need to provide for them in a legislation. My own guess is that they wouldn't be very widely used.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I want to thank you very much simply for being here. I have been hearing in more private settings from representatives of major American corporations the point of view which you have expressed this morning, but this is the first time that I have been present in a public session where this point of view has been taken.

I happen to agree with you. I think it is a courageous thing, and I mean that sincerely, for you to step forward and indicate that this is becoming a competitive factor. And while I don't think you totally dwelled upon the failure to have broader coverage as a result of cost shifting and the rest does saddle you not only with the costs of caring for your own employees and retirees, but other folks as well. And there's a question of fairness about all that.

I think the principal question that we have had raised about this whole matter has been the concern that while there may be an analogy with workers' compensation, that health care, even a minimum package, is a lot more expensive. And the concept is similar, but in terms of price this comparison may be apples and oranges. The question therefore, is are we simply going to price out of business many small ventures which in recent years have been the key to production of new jobs in our economy?

And I don't know how to balance that. I would welcome your thoughts on it.

Mr. CRANDALL. Mr. Gradison, I obviously don't know the answer to that any more than I suppose anyone does.

I would respond to it in this way. In a macro sense, in the broadest sense, we are paying for health care today. We are paying for it through various mechanisms in various States, but the dollars are being spent. So we are not talking about incremental expenditures for society as a whole, or for individual States, or for the Federal Government. We are talking about simply spreading that burden in a different way. And in my view, as I said in my testimony, I believe that the total burden will decline.

I think, therefore, that the argument which says that a particular small business enterprise cannot bear the costs, obviously it is going to have to be passed through and priced, and obviously society as a whole is going to pay the bill.

On the other hand, if all small enterprises have the same cost burden, it is very hard for me to see how that macro result is going to produce micro inequities.

On the other hand, it is very easy to see how today's situation can produce those micro inequities.

If I may take your time for just a moment to give you an example of the kind of unanticipated problems that less than explicit thinking can produce. We are talking about the Pension Guarantee Corporation, a problem with which I am sure you are all familiar. They are now talking about increasing the premiums for companies like my own, which provide benefit pension programs for all our employees.

Those of our competitors who do not provide pension plans at all will not participate in that increased cost.

So what we are talking about here is, first, the cost of providing the pension; then the cost of providing insurance for those companies that say they provide pensions but don't fund them. And both of those costs are being avoided by the irresponsible employer that simply does not provide for his employees in the first place.

That, in my opinion, is a far greater risk. I think there is a minimum price of poker, a minimum price of being in business in this country, and it is you've got to pay the minimum wage and, in my opinion, you ought to have to provide a minimum benefit package as well.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Nothing.

Chairman STARK. Mr. Moody.

Mr. MOODY. No questions.

Chairman STARK. Mr. Levin.

Mr. LEVIN. No questions.

Chairman STARK. Well, again, as a person who a long time ago in the private sector used to enjoy making speeches about corporate responsibility to smaller audiences, I think it is refreshing to hear from a leader of a major American industry who is taking extra time to do what is right.

The other thing that American Airlines does so well is it has this marvelous wine consultant in Texas who tests our California wines before he purchases them, and then sometimes he even purchases them on a basis other than price which we in California want to thank American Airlines for doing. We would like to be your part-

ners in that kind of venture any time we can. And I would be remiss without saying that your approach, just from this member's district, is deeply appreciated. I hope we can work together. I would like to try more ideas on you as we attempt to expand coverage, both in this committee and other committees of the House, to resolve the problem and get exactly to where I think you want us all to be, and that is some form of coverage that is financed on an equitable basis.

Mr. CRANDALL. Mr. Chairman, we appreciate the opportunity to be here, and we look forward to working with you, and we appreciate your excellent wines as well.

Thank you very much.

Chairman STARK. Thank you.

Our next witnesses will comprise a panel, Ms. Rosenbaum, the director of the health division of the Children's Defense Fund, and Mr. Robert Sweeney, the president of the National Association of Children's Hospitals.

My colleague and neighbor, Congressman George Miller, had wanted to be here. He chairs the Select Committee on Children and the Family, and has a strong interest in this topic but, unfortunately, he had a scheduling conflict and wasn't able to be here at this time. He may show up and will recognize you at that time.

If you would like to proceed, Ms. Rosenbaum, in any manner you are comfortable.

STATEMENT OF SARA ROSENBAUM, DIRECTOR, HEALTH DIVISION, CHILDREN'S DEFENSE FUND

Ms. ROSENBAUM. Yes. Thank you.

Chairman STARK. Welcome to the committee.

Ms. ROSENBAUM. Thank you very much for extending us an invitation to testify.

The lack of catastrophic health care cost is no longer a small problem for children, but a very major one, as you mentioned in your opening statement. Any child who is low income and uninsured faces a health care catastrophe among almost a daily basis.

If we are going to remedy the catastrophic health problem on children, we must address the needs of America's 8 million poor and near-poor uninsured children, as well as the needs of about 300,000 children who annually incur medical costs that exceed $5,000, and another 19,000 who exceed incurred cost exceeding about $50,000 a year.

In 1985, nearly one in five children and one in three poor children was completely uninsured. For low income uninsured children, even routine health care can be a catastrophic event. Unfortunately, the forces that are making children the most disinsured segment of American society are long term, and they are intensifying. They include the growth of single parent headed households in which children are three times more likely to be uninsured, the loss of high paying jobs with good fringe benefits, and a decrease in employer contributions to employee and dependent health insurance coverage costs. Thus, living in a working family means less and less for a poor child insofar as insurance coverage is concerned.

By 1985, two-thirds of all uninsured children lived in a home in which a parent worked full time and full year, and 20 percent lived with a working parent who himself or herself was insured.

Over the past several years, one-third of employers have reduced their contributions to their employees' group health insurance premiums most frequently in the case of dependent coverage. This means that poorer families can no longer afford to buy dependent coverage for their children.

Finally, major erosions in Medicaid, the public health insurance program for children meant that by 1985, even after some Federal and State improvements, the program served some 400,000 fewer children than it had reached in 1978.

Even children who are insured face major hardships when they are severely ill. Each year, 9,600 infants will require more than $50,000 worth of care in the first year of life alone. Several thousand children will need a lifetime of care that can easily amount to a million dollars or more. Even privately insured families can be destroyed by these events. Only 75 percent of all employer insurance plans include a significant stop-loss against out-of-pocket expenditures in the event of a catastrophic illness. One-third of all children have private insurance coverage that covers less than a quarter of a million dollars worth of care.

To remedy these problems, we recommend several steps. First we need to do something to assist lower income families who cannot pay the premium cost in their employer plans. This could be accomplished through a tax credit to help families meet the cost of their employer-provided insurance. It also could be provided in the form of a Medicaid subsidy to lower income working families to buy them into their employer packages.

Second, as H.R. 2300 would do, we must improve the content and depth of private insurance, in combination with a premium subsidy, in order to avoid further erosion of employer contributions.

Our fear with a bill such as H.R. 2300, which increases the content of insurance without also addressing the premium problem is that employers will divert funds now going into premium costs in order to cover the cost of a deeper coverage. An employer may decide that he is going to spend x number of dollars on employee provided benefits, and if he has to provide more depth, he will divert some of those dollars into meeting the depth requirements and away from the premium contribution requirements.

Finally we would like to see creation of a special supplemental care coordination and financial assistance program for families, insured or otherwise, whose children have health costs exceeding even those levels that are provided under a catastrophic medical wrap around program.

Thank you.

[The prepared statement follows:]

Statement of the Children's Defense Fund, Presented by Sara Rosenbaum, Director, Health Division

Mr. Chairman and Distinguished Members of your Subcommittee:

The Children's Defense Fund (CDF) is pleased to have this opportunity to testify today regarding children's catastrophic health costs. CDF is a national public charity which engages in research and advocacy on behalf of the nation's low income and minority children. For fifteen years, CDF's health division has been involved in extensive efforts to improve poor children's access to medically necessary care, including both primary and preventive services, and medical care requiring the most sophisticated and costly interventions currently available. I have submitted a longer statement for the record and will present a summary of my testimony at this time.

I. The Health Status of Children

Both ends of the medical care spectrum -- preventive and intensive -- are vital to the health and well-being of children. All children need primary care, including comprehensive maternity care prior to birth, ongoing health exams and followup treatment, care for self-limiting illnesses and impairments (such as influenza or strep), and vision, hearing and dental care. Additionally about one in five children will be affected by at least one mild chronic impairment, such as asthma, a correctable vision or hearing problem, or a moderate emotional disturbance, which will require ongoing basic medical attention.

Beyond these basic health needs, a small percentage of children require more extensive and expensive medical care; a modest proportion of this latter group will face truly extraordinary health care costs over their lifetimes. About four percent of all children (a figure which by 1979 was more than double the percentage reported in 1967)[1] suffer from one or more chronic impairments that result in a significant loss of functioning. Included in this group are children suffering from degenerative illnesses, multiple handicaps, and major orthopedic impairments. About two percent of all children suffer from one of eleven major childhood diseases including cystic fibrosis, spina bifida, leukemia, juvenile diabetes, chronic kidney disease, muscular dystrophy, hemophilia, cleft palate, sickle cell anemia, asthma, and cancer.[2] Also included in this group are the several thousand children who are dependent on some form of life support system.

Finally, nearly 7 percent of all infants are born at low birthweight (weighing less than 5.5 pounds) each year.[3] Virtually all will require some additional medical services. Moreover, about eighteen percent of all low birthweight infants (approximately 43,000 infants) weigh less than 3.3 pounds at birth and will require major medical care during the first year of life. About 9600 infants will incur first year medical costs alone that exceed $50,000, and a portion will require ongoing

care throughout their lives.[4] Low birthweight infants are at three times the risk of developing such permanent impairments as autism, cerebral palsy and retardation.[5]

II. The Health Needs of Children

Most children, even children with impairments, require relatively modest levels of health care. Only about five percent of all children incur annual medical costs in excess of $5,000.[6] However, both groups of children -- those with relatively low-cost medical care needs and those with high cost problems -- can be considered catastrophic cases, in either relative or absolute terms.

A. "Relative" Catastrophic Health Needs Among Children

For low income uninsured families, even routine child health needs can result in catastrophic expenditures if the term "catastrophic" is measured in relation to a family's overall income. In 1985, nearly one in every five children, and one in every three poor children, was uninsured.[7] (Table I) Additionally, one in six women, and one in three poor women, of childbearing age, was completely uninsured.[8]

Poor and near-poor uninsured families, when confronted with even normal child health expenditures of several hundred dollars per year, face insurmountable health care barriers. As a result, uninsured low income children receive 40 percent less physician care and half as much hospital care as their insured counterparts.[8a]

The uninsured are disproportionately likely to be children. In 1985, Children under 18 comprise 25 percent of the under-65 population, but one-third of the uninsured under -65 population.[9] Moreover, they are disproportionately likely to be poor. Over 60 percent of all the uninsured had family incomes below 200 percent of the federal poverty level, and one-third had family incomes below the federal poverty level.[10] Finally, a parent's access to employer insurance by no means assures relief for a child. In 1985 the majority of uninsured children in 1985 (65 percent) lived in families where the head was a full-time worker[11], Yet 20 percent of all uninsured children that year lived with a parent who had private coverage under an employer plan[12] (Table II).

The two main causes of children's lack of health insurance are the major gaps in the employer-based health insurance system and the failure of Medicaid, the nation's major residual public health insurance program for children, to compensate for the failings of the private insurance system.

1. **The Private Health Insurance System Is Leaving More American Children Uninsured**

Our nation relies primarily on private health insurance to meet much of the health care costs of the working-age population and its dependents. Most of this private insurance is provided as an employment-related benefit. Employer-sponsored health care plans are the single most important source of private health care coverage for Americans younger than sixty-five. In 1984, over 80 percent of all privately insured American children were covered by employer plans.[13]

Yet between 1982 and 1985 the dependent coverage aspect of the employer-provided health insurance system underwent serious erosion. In 1982, employer plans covered over 47 million non-workers, including 36 million children. By 1985, even though there were actually more workers covered by employer plans than in 1982 (88 million versus 84 million), the number of covered children dropped to less than 35 million[13a] (Table III). Indeed, the recent decline in employer-provided coverage has been most apparent among children.[13b]

As a result, the number of children without any health coverage grew by nearly 16 percent between 1982 and 1985.[13c] (Tables III and IV.)

The growing number of uninsured children in working families results from two factors. First, employers have increasingly reduced or eliminated their contributions to dependent coverage under their plans.[13d] For the two-thirds of uninsured children living in poor or near-poor working families, the financial burden of a dependent premium is impossible.

Second, the employer insurance system also completely excludes millions families of the lower end of the wage of scale -- the fastest growing part of the job sector. Thirty percent of all employers who pay the minimum wage to more than half their work force offer no health insurance.[14] As these young adult workers have families, their children are affected by their parents' lack of coverage.

Thus, the employer-sponsored health insurance system excludes those children whose parents' employers either do not offer any coverage to either workers and/or workers' dependents or else offer it only at an unaffordable cost. As a result of these two trends, a child living in a poor working family is only about half as likely to have private insurance as a similarly situated, non-poor child.[15] (Table I.)

There is every indication that the deficiencies in the private insurance system are growing, not shrinking. First, as children increasingly live in single-parent headed families,

there is a greater likelihood that they will be left without private insurance coverage. Children living in single-parent households are three times more likely to be uninsured than children living in two-parent households.[16]

Moreover, the United States is witnessing a major shift in the type of jobs the economy provides, away from job growth in the manufacturing industries and toward growth in the service sector. Manufacturing jobs generally have greater levels of employer-paid fringe benefits, particularly health insurance. Service jobs, by contrast, are generally lower-paying and often part-time. These jobs, even if full-time, are significantly less likely to provide health insurance.[17] To the extent that the American economy continues this shift, we may be witnessing the inexorable erosion of the employer-based insurance system and the resulting disinsurance of the middle class and their families over the long term.

2. Medicaid, the Major Public Insurance Program for Families with Children, Is Covering Fewer Children

Medicaid, enacted in 1965, is the nation's largest public health financing program for families with children. Unlike Medicare, which provides almost universal coverage of the elderly without regard to income, Medicaid is not a program of universal or broad coverage. Rather, it is based on need. Eligibility depends on having extremely low income.

Because Medicaid is fundamentally an extension of America's patchwork of welfare programs, it makes coverage available primarily to families that receive welfare. With a few exceptions (including pregnant women and children younger than five with family incomes and resources below state-set Aid to Families with Dependent Children levels), individuals and families that do not receive either AFDC or Supplemental Security Income (SSI) are categorically excluded. For example, a family consisting of a full-time working father, mother, and two children normally is excluded from Medicaid even if the father is working at a minimum wage job with no health insurance and the family's income is well below the poverty line. Moreover, even though states have had the option since 1965 to cover all children living below state poverty levels regardless of family structure, as of December, 1986, 20 states still failed to do so.[16]

In addition to its use of restrictive eligibility categories, Medicaid excludes millions of poor families because of its financial eligibility standards, which for most families are tied to those used under the AFDC program.[17] In more than half the states, a woman with two children, who earns the minimum wage (about two-thirds of the federal poverty level for a family of three in 1986) would find that she and her children are

ineligible for coverage.[18] By 1986, the combined impact of Medicaid's restrictive categorical and financial eligibility standards had reduced the proportion of the poor and near-poor covered by the program to only 46 percent--down from 65 percent a decade earlier.[19]

As a result of improvements enacted by Congress in 1984 and 1986, many previously uninsured low-income pregnant women and children will be aided.

- The Deficit Reduction Act of 1984 mandated that states provide Medicaid coverage to all children younger than five with family incomes and resources below AFDC eligibility levels.

- The Deficit Reduction Act of 1984 and the Consolidated Omnibus Budget Reconciliation Act of 1986 together mandate coverage of all pregnant women with income and resources below state AFDC eligibility levels.

- The Sixth Omnibus Budget Reconciliation Act (SOBRA) passed in late 1986 permits states at their option to extend automatic Medicaid coverage to pregnant women and children under age five with incomes less than the federal poverty level but in excess of state AFDC eligibilty levels.

If fully implemented in every state, these amendments will reduce by 36 to 40 percent the number of uninsured pregnant women and young children nationwide.[20]

However, even if fully implemented, these new laws will not compensate for Medicaid's growing failures. SOBRA's age limitations mean that Medicaid still will not reach low-income children over age five, and in 20 states, even extraordinarily poor children over age five are still excluded, no matter how great their poverty, simply because they live with two parents and are beyond the age mandate of the Deficit Reduction Act. Nor do these new laws aid the millions of uninsured, nonpregnant, poor parents, whether they are working or unemployed.

Moreover, these recent improvements are unlikely even to offset the years of stagnation and erosion that Medicaid has experienced. In Fiscal Year 1985, Medicaid served 10.9 million children younger than twenty-one--more than 400,000 fewer than were served in Fiscal 1978.[21] This drop occurred despite the fact that Fiscal 1985 was the first year that the 1984 Deficit Reduction Act amendments were in effect, and it followed enactment by about a dozen states of additional optional Medicaid child coverage improvements. Finally, this decline occurred even though the number of children in poverty rose from 9.7 million to more than 12.5 million over the same time period.[22]

The primary causes of declining Medicaid coverage include stagnation in Medicaid's financial eligibility levels, and, beginning in Fiscal 1982, a virtual exclusion of poor working families from the program.[23] Even in 1977, prior to the 1981 reductions, a child living in a poor working family was 1.8 times more likely to be completely uninsured than one living in a poor, non-working family.[24] This figure has undoubtedly worsened.

3. **Remedying Children's "Relative" Catastrophic Health Needs**

If children's "relative" catastrophic health needs are to be met, it is essential that they be given health insurance. This might be accomplished by requiring all employers to offer health insurance, by providing poor and near-poor families with subsidies to meet the cost of dependent coverage under their employer plans, or by expanding Medicaid to include coverage (on an income-adjusted premium basis) of any individual or family with income below 200 percent of the federal poverty level. At a minimum, however, we believe that any catastrophic health package for the under - 65 population should include the following, in order to reduce the number of poor children facing "relative" catastrophic health costs:

- Mandate Medicaid coverage of all children under age five living below the federal poverty level, to be phased in on a year-by-year basis beginning in Fiscal 1988. Such coverage is now optional.

- Mandate Medicaid coverage of all children under age 18, and 18-to-21-year-olds in school, jobs, or job training programs, whose family income and resources do not exceed their states' AFDC eligibility levels. As noted above, the 1984 reforms extended such mandatory coverage to children under age 5 but left uncovered children ages 5 to 21. Legislation recently introduced by Congressman Waxman and Senator Bradley (H.R.1018 and S.422) would increase this age limit to age 8. We recommend a further increase to age 18 (and to 21 in the case of older children enrolled in school, jobs, or job training programs), with a phase-in of all such newly eligible children over age five by 1992.

- Provide extended Medicaid benefits to all families making the transition off AFDC, including 9 months automatic coverage, and continued coverage for working families with incomes below 100 percent of the federal poverty level.

- Provide states the option of extending Medicaid to any child under age 18 (and any 18-to-21 year-old in school, job or job training) with family income below

the federal poverty level but over the AFDC eligibility level. Created this new option but presently terminates coverage at age five. The Waxman/Bradley legislation would raise the age limit to 8 years. We recommend that the age limitation be increased.

B. **"Children's Absolute" Catastrophic Health Needs**

In addressing children's "relative" catastrophic health needs by expanding the number of children with health insurance, Congress would also provide extensive relief for children with absolute catastrophic health needs which arise as a result of severe illness or disability. However, it is also evident that normal levels of insurance, public or private, are inadequate in the case of the most severely catastrophically ill or disabled infants and children, particularly the 19,000 with more than fifty thousand dollars a year in health care costs.

Our traditional notion of health insurance is that its primary purpose is to provide protection against grave health risks. But over time the nation has developed public and private health insurance systems that are designed to meet normative, rather than catastrophic, medical care needs. Both public and private health insurers have developed myriad ways to limit their exposure for high-cost illnesses and disabilities, in favor of providing subsidies for more routine and normative health needs.

- Among employers responding to a major health insurance survey conducted in 1986, 73 percent indicated that their plans exclude coverage of preexisting conditions.[25] More plans now also contain riders that exclude coverage of certain conditions that may develop among enrollees, such as cancer.

- Only about 75 percent of plans offered by medium and large-sized firms between 1980 and 1985 contained protections against huge out-of-pocket costs born by enrollees in the event of catastrophic illness.[26]

- Only 67 percent of mid-and-large-sized firms offered extended care benefits between 1980 and 1985, and only 56 percent offered home health benefits.[27]

- In 1977 only 8.3 percent of all children had unlimited private coverage for major medical benefits, and one-third had coverage for a quarter million dollars of care or less.[28]

- Fourteen state Medicaid programs place absolute limits on the number of inpatient hosptial days they will cover each year, with some states limiting coverage to as few as 12-15 days per year.[29] About an equal number place similar limits on coverage of physicians'

services. Others place strict limitations on such vital services as prescribed drugs and diagnostic services.

- Finally, both Medicaid and private insurance frequently fail to cover extended home health and related services (including such non-traditional items as home adaptation). When such coverage is available, it may be provided on a case-by-case exception basis.

The question of whether private and public insurers should be required to meet more than normative patient needs is complex, particularly since so many Americans are uncovered for even basic health needs. We believe that, as one part of a longterm effort to improve the scope and depth of public and private insurance coverage, employers should be required to include catastrophic protections as Congressman Gradison's bill proposes. However we would caution that if this mandate is not coupled with a minimum employer contribution requirement at least some employers will meet is new obligation by reducing their individual and/or family premium contributions, thereby completely disinsuring even more dependents.

We would therefore amend the Gradison bill to add a new premium subsidy for families with incomes below 200 percent of the federal poverty level. We also recommend that the definition of out of pocket expenditures include those out-of-pocket costs that ultimately may be covered by Medicaid in the case of lower income medically needy persons. Without this modification, a Medicaid-eligible person also covered by private insurance will never be able to trigger his or her private coverage, and state Medicaid programs will bear the full brunt of the beneficiary's catastrophic illness without benefit of third party liability.

Finally, we would urge this Committee to provide at least some incremental relief for the small number children facing major catastrophic illnesses, regardless of whether they live in insured or uninsured families. We believe that two basic changes are needed. First, Congress should enact a program to provide care coordination and other assistance to families whose children incur annual medical expenses in excess of $5000. This program should be administered by state maternal and child health programs under Title V of the Social Security Act.

Second, Congress should create a special fund for families of the 9600 newborns and infants whose first year medical costs exceed $50,000, and who incur out-of-pocket costs of at least $5000. While the Medicaid medically needy program provides some assistance for such families, fifteen states currently have no medically needy programs. Moreover because spend-down requirements are so restrictive, we estimate that, based on a telephone survey of state Medicaid agencies with medically needy

programs, only about 100 such medically needy infants are assisted annually. Thus, a more appropriate assistance fund is needed for families with catastrophically infants, particularly because half of all severe childhood illnesses and disabilities have their onset in infancy.

Our proposal, which would cost about $600 million for full year funding, would provide ongoing medical services to these children, in accordance with individually developed case plans (developed by Title V agencies) which emphasize community-based care in the least restrictive setting.

In conclusion, any catastrophic approach for children should address both their relative and absolute catastrophic needs. In the immediate future, we recommend expanding Medicaid to reach more poor children, enactment of Congressman Gradison's bill with two modifications, and development of a supplemental funding program to aid families whose children have major, ongoing catastrophic health needs.

FOOTNOTES

1. Newacheck, P. W., Budetti P. P. & Halfon, "Trends in Activity Limiting Chronic Conditions Among Children," 76 AJPH 178 (Feb., 1986).

2. Butler, John, et. al., "Health Care Expenditures for Children with Chronic Illnesses" Issues in the Care of Children with Chronic Illnesses.

3. Hughes, D. et al, The Health of America's Children (Children's Defense Fund, Washington, DC, 1987).

4. Institute of Medicine, Preventing Low Birthweight (National Academy Press, 1986).

5. Healthy People: The Surgeon General's Report on Health Promotion & Disease Prevention (DHHS, Washington DC, 1978).

6. American Academy of Pediatrics, Health Care Financing Newsletter (1986).

7. Chollet, Deborah, "The Erosion of Health Insurance Among the Non-Elderly Population: Public Policy issues and Options" (EBRI, Washington, D.C., 1987).

8. Gold, Rachel and Kenney, Asta, "Paying For Maternity Care," 17 Family Planning Perspectives 107 (May-June, 1985).

8a. Blendon, Robert, et. al., "Uncompensated Care by Hospitals or Public Insurance for the Poor: Does It Make a Difference?" 314 NEJM, 1160 May 1, 1986.

9. Chollet, op. cit.

10. Ibid.

11. Ibid.

12. Ibid.

13. Rosenbaum, "Children & Private Health insurance," Recent Developments in the Financing & Organization of Health Care: Implications for Children. (Harvard University Press, in press).

13a. Chollet, op. cit.

13b. Ibid.

13c. Ibid.

13d. Ibid.

14. A Children's Defense Budget, op. cit.

15. Ibid.

16. Hill, Unpublished survey, (National Governors Association, December, 1986).

17. Rosenbaum, & Johnson, "Providing Health Care for Low Income Children: Reconciling Child Health goals with Child Health Financing Realities," 64 Milbank Memorial Fund Quarterly, 442 (September, 1986).

18. A Children's Defense Budget op. cit.

19. Robert Wood Johnson Foundation, Health Care for the Uninsured Program, 1986.

20. Estimates by the Children's Defense Fund.

21. Hughes et. al., op. cit.

22. Ibid.

23. Rosenbaum & Johnson, op. cit.

24. Rosenbaum, op. cit.

25. Ibid.

26. General Accounting Office, op. cit.

27. Ibid.

28. Rosenbaum, op. cit.

29. National Association of Children's Hospitals and Related Institutions, Unpublished Data, (Alexandria, VA, March, 1987).

TABLE 4

Children Under Age 18 Without Health Insurance by Family Type and Poverty Status, and Sex and Work Status of the Family Head, 1985

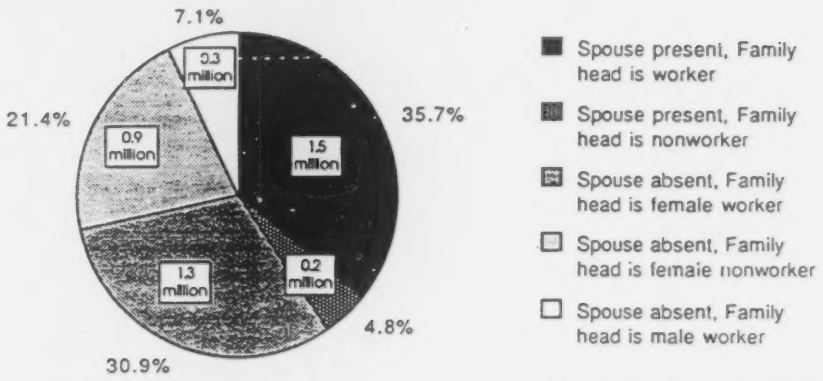
	Total	Family Income as a Percent of Poverty			
		0-99%	100-124%	125-199%	200% +
		(in millions)			
All Uninsured Children	10.8	4.2	1.1	2.4	3.1
Family Type and Work Status					
Spouse Present	5.9	1.8	0.6	1.4	2
Family Head is:					
Full-year worker	5.2	1.4	0.6	1.3	1.9
Part-year worker	0.3	0.1	a	0.1	a
Nonworker	0.3	0.2	a	a	a
Spouse Absent	4.9	2.4	0.4	1.0	1.1
Family Head is:					
Male	1.0	0.3	0.1	0.2	0.3
Full-year worker	0.7	0.2	a	0.2	0.3
Part-year worker	0.1	0.1	a	a	a
Nonworker	0.1	a	a	a	a
Female	4.0	2.1	0.3	0.8	0.8
Full-year worker	2.5	0.9	0.3	0.6	0.7
Part-year worker	0.5	0.4	a	a	a
Nonworker	1.0	0.9	a	a	a
		(percents within family status groups)			
All Uninsured Children	100.0%	100.0%	100.0%	100.0%	100.0%
Family Type and Work Status					
Spouse Present	54.6%	42.9%	54.5%	58.3%	64.5%
Family Head is:					
Full-year worker	48.1%	33.3%	54.5%	54.2%	61.3%
Part-year worker	2.8%	2.4%	a	4.2%	a
Nonworker	2.8%	4.8%	a	a	a
Spouse Absent	45.4%	57.1%	36.4%	41.7%	35.5%
Family Head is:					
Male	9.3%	7.1%	9.1%	8.3%	9.7%
Full-year worker	6.5%	4.8%	a	8.3%	9.7%
Part-year worker	0.9%	2.4%	a	a	a
Nonworker	0.9%	a	a	a	a
Female	37.0%	50.0%	27.3%	33.3%	25.8%
Full-year worker	23.1%	21.4%	27.3%	25.0%	22.6%
Part-year worker	4.6%	9.5%	a	a	a
Nonworker	9.3%	21.4%	a	a	a
		(percents within poverty status groups)			
All Uninsured Children	100.0%	38.9%	10.2%	22.2%	28.7%
Family Type and Work Status					
Spouse Present	100.0%	30.5%	10.2%	23.7%	33.9%
Family Head is:					
Full-year worker	100.0%	26.9%	11.5%	25.0%	36.5%
Part-year worker	100.0%	33.3%	a	33.3%	a
Nonworker	100.0%	66.7%	a	a	a
Spouse Absent	100.0%	49.0%	8.2%	20.4%	22.4%
Family Head is:					
Male	100.0%	30.0%	10.0%	20.0%	30.0%
Full-year worker	100.0%	28.6%	a	28.6%	42.9%
Part-year worker	100.0%	100.0%	a	a	a
Nonworker	100.0%	a	a	a	a
Female	100.0%	52.5%	7.5%	20.0%	20.0%
Full-year worker	100.0%	36.0%	12.0%	24.0%	28.0%
Part-year worker	100.0%	80.0%	a	a	a
Nonworker	100.0%	90.0%	a	a	a

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

TABLE II

Children Under Age 18 Without Health Insurance Living in Poverty by Family Type, 1985



Note: The number of uninsured poor children living with a single male nonworker is too small to be statistically reliable

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Table III

The Civilian Nonagricultural Populationa/ Without Health Insurance and Percent by Own Work Status, 1982 and 1985

Work Status	1982 People (millions)	1982 Percent	1985 People (millions)	1985 Percent	Percent Change 1982-1985
Total	30.3	15.6%	34.8	17.4%	14.9%
Workers	16.0	13.9%	19.1	15.5%	19.4%
Family Head b/	10.4	14.1%	12.3	15.6%	18.3%
Other	5.6	13.4%	6.8	15.3%	21.1%
Nonworkers	14.2	18.2%	15.6	20.4%	11.0%
Children c/	9.6	17.0%	11.1	19.7%	15.6%
Other	4.7	21.3%	4.6	22.8%	2.1%

Source: EBRI tabulations of the March Current Population Survey and the March 1986 Current Population Survey.

a/ Data exlude people under age 65 employed in the military or in agriculture, and members of their families.

b/ The family head worker is the family or subfamily member with the greatest earnings; all other family members with earnings are designated as secondary workers. Family head workers include unrelated individuals who are workers.

c/ People under age 18 who reported no earnings and were not the family head.

Table IV

Civilian Nonagricultural Population a/ With Private Health Insurance Coverage by Own Work Status and Source of Coverage, 1982 and 1985

Work Status	1982 Total Private Coverage	1982 Employer Coverage	1982 Other Private Coverage	1985 Total Private Coverage	1985 Employer Coverage	1985 Other Private Coverage
			(In millions)			
Total	146.9	130.8	24.0	147.6	131.8	23.0
Workers	92.9	83.7	14.7	97.1	87.6	14.8
Family Head b/	57.5	51.1	9.9	60.3	53.6	10.0
Other	35.4	32.6	4.8	36.8	34.0	4.8
Nonworkers	54.0	47.1	9.3	50.6	44.3	8.2
Children c/	39.5	36.1	4.9	37.7	34.9	4.1
Other	14.5	10.9	4.4	12.8	9.4	4.1
			(percent within work status group)			
Total	75.8%	67.5%	12.4%	73.9%	66.0%	11.5%
Workers	80.4%	72.4%	12.7%	78.8%	71.0%	12.0%
Family Head b/	78.1%	69.4%	13.4%	76.5%	68.0%	12.0%
Other	84.4%	77.7%	11.6%	82.7%	76.4%	10.8%
Nonworkers	69.1%	60.3%	11.8%	66.1%	57.9%	10.7%
Children c/	70.1%	64.3%	8.7%	66.8%	61.9%	7.3%
Other	66.3%	50.0%	19.9%	63.4%	46.5%	20.3%

Source and Notes: See table

Chairman STARK. Thank you.
Mr. Sweeney.

STATEMENT OF J.E. STIBBARDS, PH.D., CHAIRMAN, BOARD OF TRUSTEES, AS PRESENTED BY ROBERT H. SWEENEY, PRESIDENT, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS

Mr. SWEENEY. Thank you, Mr. Chairman.

I am Robert Sweeney, and I am president of the National Association of Children's Hospitals and Related Institutions.

It had been our intention that our Chairman, Dr. Stibbards, from the Buffalo Children's Hospital would be presenting this morning. Apparently a mixup in our communications and also the vagaries of Washington traffic have delayed him. So I will, if I may, present the statement.

Chairman STARK. Please.

Mr. SWEENEY. On behalf of our 94 Children's Hospitals, let me thank you for the opportunity to testify. Our proposals have the potential for future savings in health care costs through prudent and modest investment today in our children.

Our association has adopted a policy statement Catastrophic Illness Expense and Children. Many of the points made in that statement are included in our detailed testimony submitted today which I will summarize and highlight appropriately.

Although for the vast majority of children, good health is a normal state, our data shows that in 1985, of the 8.4 million children and infants hospitalized, 176,000 had hospital charges over $10,000. In fact, averaging $25,600. Add to that physician fees and other necessary expenses, and we are talking catastrophe for many American families, even those families who are seemingly adequately resourced for routine medical expenses.

One-half of these children were under 1 year of age, suggesting younger families in the early stages of their earning capacities. The financial insult incurred can be one from which these young families will never recover, and the very stability of the family unit can be jeopardized.

If the family is poor, any medical expense can be catastrophic. Even when they cannot pay for such care, none of it, of course, is free. Rather, it is distributed throughout our economy and our society haphazardly with no particular plan or reason.

This amounts to unofficial taxation, enacted not in furtherance of but in lieu of reasonable public policy. Providers curtail plans for new and needed services to meet the cost of caring for the poor, or they become unofficial taxing agents, passing costs to other patients or their insurers.

That alternative is rapidly disappearing in our "market-oriented" health economy.

States impose taxes on hospital revenues for redistribution of funds from the protected sick to the unprotected sick.

Cruelest of all is the confiscatory tax on the child, resulting when his parents forego or postpone necessary or indicated health care, because they do not have adequate resources to provide it. That tax compromises the child's future well-being. It threatens his

educability. It may diminish his future earnings capacity. It is a tax which must be repealed.

This then is the pervasiveness of catastrophic illness expense in children. The child with no resources available for his care; the high cost of today's technologically driven care with its seeming marvelous cures; and finally those children whom we can save, but for whom the knowledge has not yet arrived to cure or prevent. The resultant cost of severe chronic illness can be devastating to his family.

This subcommittee and the Committee on Ways and Means have moved promptly and effectively to address some of the catastrophic illness problems of Medicare beneficiaries. The administration's proposal has been enhanced to assist those facing major expenses from Medicare covered services, or threatened by that potential.

For children, there is no equivalent to the Medicare vehicle to which a solution can be affixed except for those 2,000 children eligible for Medicare's end stage renal disease program.

For the families of children whose resources are inadequate or exhausted, a number of public policy initiatives are indicated. Many of these indicate taxation, but taxation which is rational and in furtherance of a public policy toward preserving the health status of our children.

Since employment-related health insurance remains the dominant mechanism for protecting the working population, we would urge the following:

One, the prompt enactment of H.R. 2300, the Catastrophic Illness Expense Protection Amendments of 1987, cosponsored by the chairman and the ranking minority member, to require employers to add catastrophic or stop-loss protection to health benefits.

Although we recognize that no attempt is made to prescribe benefits of the basic health protection plan, care must be taken that employers are not encouraged to finance costs of a catastrophic protection by increasing copayments and deductibles on basic coverage, particularly among low income workers.

Further, particularly in the care of young children, the catastrophic coverage required should include a requirement for home, or alternative site care in lieu of acute hospital care when medically indicated and appropriate to the family situation.

This has been demonstrated to be cost-effective, extending insurance benefits and most certainly is humane. All that has been lacking is the required resources. H.R. 2300 would correct that lack.

Second, we would require all employers to provide a minimum health benefit package for employees, including prenatal and well child care. Such might be accomplished in a variety of ways, including tax incentives to employers of predominantly lower income employees, and an excise tax on employers not providing such benefits.

Third, for workers above 200 percent of the poverty level, health insurance benefits should be taxable unless the employee covers his dependents. Alternatively, a portion of their standard deduction for dependents should be disallowed unless these employees include their dependents in their insurance benefit.

Fourth, we would encourage creation at the State level of insurance pools for small employers, the self-employed and seasonally employed persons.

Fifth, we would encourage States, in combination or separately, similarly to establish risk pools for the the uninsurable, and catastrophic insurance pools for small employers and with the risk pools, subsidized if necessary by State or Federal taxes on insurers and self-insured businesses.

Sixth, we need to protect the needs of the poor and the near poor through comprehensive expansions in the Medicaid program, including mandating coverage for pregnant women and children under age 6, whose incomes are below the Federal poverty level as an extension to the Waxman-Bradley bill.

Next, we should eliminate State-to-State discrepancies with regard to eligibility and the extent of services provided by the Medicaid program.

And finally, require that any savings to the State in the Medicaid program resulting from the Medicare changes, particularly the catastrophic changes which you are in the process of making, be maintained within the State Medicaid program.

Mr. Chairman, we have suggested in the interest of children, six vehicles to which their catastrophic illness expense needs can be affixed. Three of these, requiring catastrophic protection in health benefit plans, requiring health benefit plans of employers; and using tax policy to encourage workers with sufficient earnings to protect their dependents; fall within the jurisdiction of the Committee on Ways and Means.

The prestige of this committee will add momentum to the others.

Please be assured that NACHRI as an organization stands ready to assist in any way possible the committee and its staff in your endeavors. And I thank you for the opportunity to present this statement.

[The prepared statement follows:]

STATEMENT
OF THE
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS
AND RELATED INSTITUTIONS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

ON
CATASTROPHIC ILLNESS EXPENSE AND CHILDREN
CATASTROPHIC HEALTH INSURANCE

May 12, 1987

Presented by J.E. Stibbards, Ph.D.
Chairman, Board of Trustees

The National Association of Children's Hospitals and Related Institutions is a voluntary association dedicated to promoting the health and well-being of children. NACHRI is the only national organization of children's hospitals in the country. It represents 94 children's hospitals. All are nonprofit. Virtually all are teaching hospitals. Many are committed to research. All are deeply involved with the communities they serve and generous with charitable care.

For children's hospitals and the families they serve, catastrophic illness expense is the major public policy issue.

The subcommittee and the Committee on Ways and Means have moved promptly and with effectiveness to take action on catastrophic illness expenses occurring to Medicare beneficiaries. The Administrative proposal for such protection has been enhanced and will assist those facing major expenses in Medicare covered services, and give peace of mind to others to whom the potential for such expenses are a continuing concern. We recognize the subcommittee's concern that additional catastrophic expense may confront the elderly and disabled, particularly drugs and long term care costs, and that these are matters for further consideration. The elderly are, in good measure, the grandparents indeed and the great grandparents of those to whom childen's hospitals are committed, and the bond between them is such that frequently these grandparents devote their limited resources to the well being of their grandchildren, particularly when illness strikes. Help to grandparents then, is help to the child, and to the child's parents. We must be mindful the generations are mutually supportive, and mutually dependent.

Children with catastrophic illness expense are served in very limited numbers by Medicare through the End Stage Renal Disease program, which provides a predictable flow of resources to families to meet the costs of treatment. While the improvements to Medicare coverage will undoubtedly assist the 2000 families whose chldren suffer from this condition, it would not alleviate the burdens faced by thousands of others.

For a family, any child's illness or injury can be just as catastrophic as that of a grandparent. To a family without resources to provide adequate care for a child, otherwise routine health care expenses are catastrophic. Although this happens primarily among families who are uninsured, underinsured, or uninsurable, no one is immune from illness expense of catastrophic proportions. High technology care now available where previously no treatment was possible, can bring with it high costs and the dilemma of payment to those whose resources are sufficient for routine and anticipated services.

DEFINING "CATASTROPHIC ILLNESS EXPENSE"

The threshold of "catastrophe" is relative to those resources which can be dedicated to illness expense without severe and lasting effect on living standards or other essential needs. For the elderly, protecting against catastrophe often focuses on maintaining living standards or guarding static resources needed for future living expenses. A young family is more concerned with building for the future, saving for education, or progressing toward a higher living standard. Catastrophe in this case threatens the stability of the family's current economic status and achievement of future goals.

Financial catastrophe may have several levels. Where a family's resources are severely limited, even minor events will result in financial catastrophe. As available resources increase, the threshold of financial catastrophe also increases. Yet there is always the potential for a serious or lasting erosion of the family's standard of living.

Of course catastrophe is not simply a financial concept. The stress of a child's illness or injury places emotional and social burdens on the entire family. A parent may have to cease working, leading to a decreased family income during a period of increased resource needs, with resultant stress. Siblings suffer from loss of parental attention and deprivation from the economic sacrifices imposed, such as loss of savings for higher education. As a whole, the family suffers from disruption of a stable and predictable family life-style. These emotional and social stresses affect families of all economic levels, though those with more adequate means or other support systems will absorb the shock better than others.

Catastrophic illness expenses in the pediatric population may derive from one or more of three sets of circumstances:

- Acute care needs which are sudden and episodic in nature:
  - Approximately 220,000 premature babies are born each year; with intensive care nursery charges approximately $1,000/day, average hospital charges are over $35,000 for an immature infant
  - Heart surgery for a child may cost a family $22,000 for a hospital stay
  - Treatment for extensive burns may result in a hospital bill of $45,000
- Chronic care needs which are on-going, have a cummulative effect, and are likely to be coupled with spells of acute illness:
  - Comprehensive care for children with cystic fibrosis can cost a family $6,000 - $12,000 annually; intermittent hospitalizations may average over $7,000 per stay
  - Institutional care for a ventilator dependent child may amount to $350,000 annually
- Primary care needs which are catastrophic for those with no insurance or very limited resources, which prevent their being properly addressed:
  - Treatment for an episode of asthma may cost a family $600
  - Routine hospitalization may incur costs of $700/day

CATASTROPHIC ILLNESS EXPENSE IMPACT ON POPULATION SEGMENTS

Catastrophic expenses can befall all segments of the population. The extent to which a family will be faced with hardship will be determined to a great extent by the resources it has available to meet the need. Since health insurance is a prime resource, the scope of the catastrophic illness expense problem can be examined better by grouping the population by extent of insurance protection:

- The uninsured, estimated to be some 35 million Americans who are without health insurance

- The underinsured, another 10 million who may have insurance part of the year, or who have very limited benefits

- The uninsurable, who, because of health status, cannot obtain health insurance at a price they can afford

The uninsured are people who are unemployed, or whose employment does not offer health benefits for employees and/or their children. Often these individuals are employed part-time or seasonally. Yet, 55 percent of the uninsured in America are adults who do work. Eleven million of the uninsured are dependents of employed adults, 18 years old or younger.

Some individuals, such as self-employed businessmen and farmers, do not qualify for group coverage and must depend on costly - often unaffordable - individual coverage for themselves and their families. Individual policies are apt to include clauses restricting coverage for specific diseases, exclusion of coverage for pre-existing conditions, and very high premiums.

Lack of insurance and other available resources for health care results in immediate barriers to access. Adults may lack access to basic primary and preventive care. Mothers may not have access to adequate prenatal care, resulting in severely impaired premature infants or failure-to-thrive infants. Such births may represent a relatively short-term crisis, perhaps three months of intensive care, or they may result in chronic disabilities requiring years of specialized care, frequently with episodes of acute needs.

Parents may lack resources to provide for a child's short-term acute episodes of illness, such as asthma and ear infections. Left untreated, acute episodes may lead to serious, chronic, and disabling conditions.

Even when resourced to meet basic needs, a family may lack adequate protection for treatment of chronic conditions, rehabilitation, or the special support needed between acute episodes of a chronic condition.

Institutionalization may be mandated, despite preferences for and appropriateness of home care, in order for the family to receive public support.

MEDICAID AND CATASTROPHIC ILLNESS EXPENSE FOR THE POOR

Medicaid, the federal/state health care program for the poor and the major public program for child health, does not provide adequate coverage. In 1983, children under age 18 accounted for 38 percent of the poverty population. AFDC children were 44 percent of Medicaid recipients, but caused only 12 percent of Medicaid expenditures. In the same year, those over age 65 constituted 11 percent of the poverty population but were 16 percent of Medicaid recipients. In sum, the elderly, blind, and disabled accounted for 75 percent of Medicaid expenditures.

Medicaid is an inconsistent national resource. States have overly broad discretion in determining eligibility and services covered. The variability by state of Medicaid coverage makes the program inherently inequitable in its services, simply as a function of geography. For example, in 1984, eligibility income in Alabama was 17 percent of the federal poverty level, while in California it was 74 percent. In that year, the poverty level for a family of four was $10,200. Overall, the average eligibility income in 1984 was only 38 percent of the federal poverty level.

States also are authorized to impose limits on services, including mandated services, within established guidelines. For example, in 1984:

- fifteen states imposed limits on the number of inpatient hospital days per spell of illness, ranging from 10 to 45 days

- fifteen states limited coverage for specific procedures

- twelve states limited the number of outpatient hospital services/visits per year

- fifteen states required prior authorization for certain services or procedures; and

° six states limited psychiatric services

Where coverage is limited by scope of services or eligibility levels, care often is delivered by the provider without compensation, which may mean that the provider cannot adequately or consistently support comprehensive services for all those in need. Further, changes in the health care marketplace make it increasingly difficult to transfer the cost of care of those who cannot pay to those who can.

States have the option to provide a Medically Needy Program, in which individuals can become eligible for coverage based on the amount of their incurred medical expenses. However, to date only 34 states have adopted this option. Again, within the Medically Needy Program, states control eligibility through levels of projected income, allowable resources, and length of time during which persons must spend down their resources. Even the Medically Needy option is lacking, with eligibility on average reaching only 51 percent of the federal poverty level.

FAMILIES ABOVE THE POVERTY LEVEL

People who are "near poor" and "middle class" often are underinsured. The economy is increasingly service-based, with large numbers of unskilled or semi-skilled part-time employees. Between 1979 and 1984, 60 percent of newly created jobs paid less than $7000 annually. Employers are not required to provide benefits for employees, or their dependents, and, in fact, in 1985, 15% of all workers had no employer sponsored health insurance protection. Of those earning less than $10,000 per year, 28% had no health care cost protection, public or private. Further, twenty percent of uninsured children lived with an employed covered worker who was either parent or spouse. There is no substantial incentive, such as a tax benefit, to encourage employees to select comprehensive health coverage for their children.

Even families with good incomes may face devastating costs with the illness of a child, especially if the need is for long-term care or treatment not covered by traditional insurance policies. A 1986 study by the United Cerebral Palsy Association depicts the costs commonly associated with this chronic condition, and the amount borne by the family:

° For surgical procedures, private insurance pays up to 80 percent

° Expenses for wheelchairs, braces, and special adaptive devices represent a continual drain on family resources; the equipment purchased by many families is "dictated by availability of funds rather than...the need"

° Families usually bear the entire cost of making a home accessible to a handicapped child

° Special transportation costs are also met almost exclusively by families

° Current expenses, including doctor bills, speech therapy, and medication average $4490 annually, with 51 percent paid by the family. Such families face the burden of continuing and accumulating health care costs which in sum, are catastrophic

The uninsurable population is comprised of individuals, both children and adults, whose health status precludes them from obtaining health and life insurance. This population is increasing as demographics demonstrate the gradual aging of America and the increasingly successful application of medical technology. People who previously died from serious diseases are now able to live with those diseases, yet often with a constant drain on their resources and exclusion based on medical history, from affordable insurance protection.

Approximately nine percent of Americans have a serious illness, and one to two percent of all children in America have a severe chronic illness. A 1986 study by Communicating for Agriculture shows that of rural Americans surveyed in five states over the past three years, 10 percent had been denied health insurance because of health status.

PRINCIPLES OF A POLICY FOR CHILDREN

A number of basic principles can be identified that guide recommendations for a solution to catastrophic illness expense for children:

° This issue is primarily one of equity and access to care for all children

- Medical science has shown what can be achieved when children receive adequate preventive, palliative, and anticipatory services

- Society responds positively in individual cases, such as when pleas are made to extend all that medicine can offer, as in the case of organ transplants

- It is ethically unacceptable that care be available only to those with resources to pay

- Society has deemed the elderly entitled to appropriate and necessary health care through the Medicare Program. To assure that the generations are not divided arbitrarily, children deserve the same consideration

° The issue is one of maintaining family integrity and stability

- Care should be provided in the setting that maintains and encourages a stable family situation

- When a child is ill, the whole family feels the impact, both socially and economically. A goal of public policy must be to ameliorate the economic disruption of the family, which is a leading cause of family disintegration

- Public policy in welfare reform and education has stressed the importance of maintaining the fabric of the family. Health care policy deserves the same emphasis

° The issue encompasses more than high-technology, expensive care

- Public policy must respond to the variety of situations that can be considered catastrophic. Primary care needs for the poor and chronic care needs must be met as well as the needs of the severely ill child

- As the problem has no single cause, the solution will not come from a single resource. Public policy must draw on all facets of society, incorporating efforts by both the private and public sectors, and the family

° Safeguarding the health of children is an investment in the future

- There is a compelling interest on the part of government to ensure the safety and well-being of children, so that future generations will be at least as stable and independent as the present

- There is likely always to be a segment of society that cannot adequately provide for itself, and must turn to the public for assistance

- We demonstrate our worth as a society by providing for those who are most in need--including those children who suffer from catastrophic illness expense

° The issue resolution must not overlook the current need to be budget-realistic

- Public, congressional, and executive commitment to reduction of the federal deficit is clear

- Cost containment and quality assurance are essential components of catastrophic care coverage. Clinical care management is a process that should be used to
  - Facilitate earliest possible discharge to the home environment or the least restrictive alternative care setting
  - Coordinate the provision of quality ambulatory services at the lowest cost

PUBLIC AND PRIVATE INITIATIVES TO REACH CHILDREN IN NEED

Employment-related health insurance remains the dominant mechanism for protecting the working population. The association has identified a number of public policy initiatives to strengthen this resource, including:

- The requirement that all employers provide a minimum health benefits package for employees, including prenatal and well child care. Such might be accomplished in a variety of ways, such as tax incentives to employers of lower income employees, or imposition of an excise tax on employers who do not provide such benefits
- The development of state level insurance pools to reduce the costs of such protection for participation by small employers, self-employed, and seasonally-employed people. Allow, if actuarially sound, uninsurable people to purchase from this pool; or
- The establishment, if necessary, of separate state risk pools for the uninsurable, subsidized by such means as a state tax on health insurance premiums or the cost to self insured employers of providing such benefits
- The prompt enactment of HR 2300, the Catastrophic Illness Expense Protection Amendments of 1987, sponsored by the ranking minority member and co-sponsored by the Chairman, to require employers to add catastrophic or "step loss" protection to health benefits. Care must be taken that employers are not encouraged to finance the catastrophic protection by increasing co-payments and deductions on basic coverage or its scope. To do so would dis-entitle the many to add protection to the few whose health costs became overwhelming.

Further, particularly in the care of young children, the catastrophic coverage required should include home on alternative site care in lieu of acute hospital care when such is medically indicated. It has been demonstrated amply that when adequate resources are available for its provision to technology-dependent infants, such care is the interest of child and family, and cost effective.

Additionally, the development of state or regional catastrophic insurance pools should be encouraged, which such coverage is not cost effective for small employers, or insurance pools.

The encouragement of other insurance pools to buy into the catastrophic pool along with other beneficiaries to maximize risk-sharing

- For workers above 200% of the poverty level, the taxation of employees on their health insurance benefits unless they cover their dependents; alternatively, disallow a portion of their standard deduction for dependents unless those dependents are included in their insurance benefit
- The protection of the poor and many of the near poor through comprehensive expansions in the Medicaid Program including:
  - mandating coverage for pregnant women and children under age six whose incomes are below the federal poverty level; and
  - eliminating state-to-state discrepancies with regard to eligibilityand the extent of services provided

- requiring that any savings to the states in the Medicaid program accruing from Medicare changes be maintained within Medicaid

° The inclusion of children in any demonstration project or study of catastrophic coverage

- Secretary of Health and Human Services Otis R. Bowen recommends a long-term care study for the elderly; this study should include children with long-term care needs

- Secretary Bowen recommends a demonstration project of catastrophic benefits for Federal employees; such a demonstration should include children

° The initiation by the Federal Government of a new study of health care costs, utilization, and resources that includes children

- Current aggregate, national data of this nature are lacking, with the NMCES study now ten years old; during which time dynamic changes have occurred in the nation's economy.

The needs of children for catastrophic illness expense protection are varied and pervasive. Many opportunities exist for the sub-committee to move to address them. NACHRI and its member hospitals stand ready to assist. We renew our pledge to provide optimum health care services in a cost effective manner, in the interests of the children and families we are privileged to serve.

References Used in the Preparation of This Statement

Aday, L. A., and Anderson, R. M. Insurance coverage and access: implications for health policy. Health Services Research, 1978. 13:369-77.

Arnett, Ross H., and Trapnell, Gordon R. Private Health Insurance: New Measures of a Complex and Changing Industry. Health Care Financing Review. Winter, 1984. Vol 6 No 2. 31-42.

Berki, S. E. et al. Health insurance coverage of the unemployed. Medical Care. 1985 July. 23(7):847-54.

Bowen, Otis R., Catastrophic Illness Expenses. Department of Health and Human Services Report to the President, Washington, D.C., November 1986.

Chollet, Deborah, "Uninsured in the United States: The Nonelderly Populatin without Health Insurance". Employee Benefit Research Institute, Washington, D.C. 1987.

Davis, K. and Rowland, D. Uninsured and underserved: inequities in health care in the United States. Milbank Memorial Fund Quarterly/Health and Society. 1983. 61(2):149-76.

Farley, P. J. Private Insurance and Public Programs: Coverage of Health Services Data Preview 20, National Health Care Expenditures Study. DHHS Publication (PHS) 85-3374. DHHS, NCHSR and HCTA. 1985.

Farley, Pamela J. National Health Care Expenditures Study Data Preview 23: Private Health Insurance in the U.S. DHHS, PHS, NCHSR. Sept. 1986.

Feder, J., Hadley, J., and Mullner, R. Poor people and poor hospitals: implications for public policy. Journal of Health Politics, Policy and Law. 1984a. 9(2):237-50.

Fox, H., and Yoshpe, R., "Technology-Dependent Children's Access to Medicaid Home Care Financing," OTA contract paper, August 1986.

Fox, H. A Preliminary Analysis of Options to Improve Health Insurance Coverage for Chronically Ill and Disabled Children. Prepared for DHHS--Division of Maternal and Child Health. September, 1984.

Kasper, Judith D., Children's Physician Access. Paper presented at the Annual Conference of the American Public Health Association, Dallas, Texas, November, 1983.

McManus, Margaret, et al. Catastrophic Childhood Illness. Child Health Financing Report. Spring, 1986. Vol 3 No 3. 1-3.

Monheit, A.C., et al. The Employed Uninsured and the Role of Public Policy. Inquiry, 22-348-364. Winter, 1985.

National Association of Children's Hospitals and Related Institutions, The Children's Hospital Case Mix Classification System Project. 1986.

Newacheck, P. Prevalence and Severity of Chronic Conditions Among Children. Prepared for the National Maternal and Child Health Resource Center as part of a National Report on Future Direction and Public Services for Children with Specialized Health Care Needs. February, 1985.

Perrin, James M., "Chronically Ill Children in America," Caring:16-22, May, 1985.

Rosenbaum, S., "Children and Private Health Insurance," Recent Developments in the Financing and Organization of Health Care: Implications for Children (in press).

Trippler, Aaron K., Comprehensive Health Insurance for High Risk Individuals — A State-By-State Analysis. Communicating for Agriculture, Minneapolis, MN., August, 1986.

U.S. Congress, Office of Technology Assessment, Technology and Child Health, (in press).

Williamson, Merna N., Cost Survey: In Depth Resource Material Prepared for Affiliates of United Cerebral Palsy Associations, Inc., January, 1986.

Chairman STARK. Well, I want to thank, on the one hand, both of the witnesses. On the other hand, I was afraid you would be here and propound what for us, unfortunately, is the unanswerable.

I suspect that if we did some things, as Ms. Rosenbaum suggests, like lower the threshold for Medicaid or set a Federal minimum, we could increase our costs $20 billion a year without trying.

Medicare, and the only figures that I have handy, costs us now about an average of $4,400 a person, as all of that is paid for out of premiums. Now presumably, that would go down with age till you got involved with pregnancy which would raise the cost in childbearing years. But even if you took 10 million uninsured, you are talking $40 billion a year, 20, 40. I mean the numbers are numbers—we just run into an absolute stone wall.

The reason we stayed away from long-term nursing home care is we very quickly got $15 to $20 billion a year, and it would be an awesome choice for us to say what do you want to do? Do you want to take $20 billion to start with seniors who need long-term care for Alzheimer's, or do you want to start with kids who need it? Then you are at $40 billion—the magnitude of it is staggering.

I suspect that you touch on the answer, Mr. Sweeney, if you believe—and I do—Mr. Crandall's approach that if we could take a long enough range look, and by that I mean four or five years, we would all save money. This care is being provided, albeit tardy and minimally, and somebody is paying for it, one way or another, and we might find a more efficient way if we knew the costs. We are really not focusing on that. It is frustrating. I would hope, and it would be an exciting challenge, that we could extend the principle of Medicare. It is certainly the most efficient program we know of in terms of returning as many dollars into the system.

I am not sure cost containment is as good, say, as industry or some of the private purchasers. But insofar as an insurance program, we are pretty efficient. Mostly we swallow the overhead.

If only we could extend the Medicare, have a minimum Medicare for youngsters or some type of benefit that could be purchased. I think you hit it, Ms. Rosenbaum, with your idea to let people buy into Medicaid even if they are above poverty. Maybe the higher they got above poverty, the higher the premium.

Last week we sort of established an income related payment. As I say, I think the committee would be open to those sorts of things. Selling it to the taxpayers is a real problem because you know, it could quickly get budget busting attached to it, and socialism could get attached to it—all kinds of very frightening terms. I hope you will bear with us.

I hope that you will give us the benefit of empirical sorts of research, and let me just propound to you an area where we can't get an answer. But instinctively I think that I am right.

The areas of the very highest infant mortality, shamefully, are Oakland, California and Washington, D.C., where we get up around 20,000 when our national average I guess is closer to 10 if you take out the disproportionate share areas.

If we were to do a program that might be 6 months of prenatal and gynecological care, and pediatric care the first year, then the savings in the next 5 to 10 years of the child's life would be of many multiples of the cost of providing that service. Now, we can't

get budget scoring, as they call it, for that. They will score us for the money we spend, and score and scorn. But they won't give us credit for what we might save in the outyears.

Regardless, if we knew more accurately what those costs might be, or could estimate them, we would at least have something to argue about—the return for our investment. That is an area where rather than anecdotal evidence, which is available in embarrassing quantities, the idea of trying to quantify some of this, seems very harsh. But we are going to have to do it, I think, before we can get the attention of the people.

Ms. ROSENBAUM. This past year, as part of our annual study on the health of America's children, we attempted to quantify the costs to the nation of not having brought the incidence of low birth weight down as quickly as the Surgeon-General projected we should be able to in 1978. Our figures, which are simply based on an arithmetical comparison of the first-year cost of healthy babies in a reduced low birth weight situation compared to first-year costs of very small babies, led us to conclude that the nation in this decade alone has spent more than $2 billion beyond what it would have spent had prenatal care been available enough to bring down the incidence of low birth weight, as we know prenatal care will when it is early, comprehensive and consistent.

We can offer you that figure now. We can also offer some early results from ongoing research in a number of States. We have been looking with the help of New York State, at the cost of a cohort of low birth weight infants. One of our early conclusions from some of the early records is that approximately 50 percent of the children in special education settings in New York were born at low birth weight. This means that the higher costs associated with special education are heavily attributable to infants who have been left with grave morbidities, ranging from retardation, autism and cerebral palsy to poor vision resulting from the resuscitation techniques that are used to aid infants born prematurely, hearing loss, and nerve damage.

These infants show up in the special education population in tremendous disproportion to their proportion in the infant population.

So we know at this point far more than that a dollar's worth of prenatal care saves three. We actually know that by not having furnished prenatal care, we have spent this decade alone $2 billion more than we should have, and we have not gotten healthy children as a result. Children have survived, and many thousands have been healthier than they would have been without the technologies, but many of them will not be healthy.

I would like to make a couple of other points if I may. One is that this is unfortunately for children, we have an extremely pluralistic health care financing situation and this isn't going to change any time soon. Since 20 percent of uninsured children live in families who have access to employer provided health insurance. But can't afford to buy the dependent coverage that the employer offers, it would be relatively inexpensive to furnish those families with some sort of subsidy to help them meet the costs of dependent coverage.

For the remaining children, certainly your proposals to allow the development of insurance pools, which are similar also to a number

of proposals that States are putting forward would help not only high risk uninsurable families who don't have access to other insurance but also lower income families who also could buy insurance through a pooling system.

We are excited about the experiments going on now in a number of States, Michigan, Washington State, and other States, to set up pooling arrangements for low income families.

We think that it would cost about $4 or $5 billion to bring all poor pregnant women and children under 18 onto the Medicaid program. These children can't afford even in a pooling system or subsidized system to contribute anything.

Chairman STARK. That was my next question. I was just going to ask that if we had $2 to $4 billion a rich aunt left us, or rich uncle, where would you spend it?

Ms. ROSENBAUM. I would add the children and pregnant women to Medicaid immediately. As many as we could get on.

Chairman STARK. Mr. Sweeney, do you have a bite-sized wish list? Where would you spend the first couple of billion?

Mr. SWEENEY. Although we come from and represent providers which are probably at the apex in tertiary level care, children's hospitals around the country, I would agree with Sara that the first place to put that kind of money is in prevention, amelioration of the problem.

We can keep plugging fingers in the dike like the little Dutch boy. But eventually we get to 10, and we are still going to have leaks in that dike. We have got to make a concerted effort to head off the problem, if you would, Mr. Chairman, rather than to try to bandage it after it occurs.

One of those little babies, about which Sara spoke, who ends up in a neonatal intensive care unit in a children's hospital or in a tertiary center of any sort can cost in the first 18 hours of life what it would cost to provide that mother with comprehensive management of her pregnancy.

We put some data together that shows that of the 3.8——

Chairman STARK. Can you quantify that for me? I mean what are you talking about in dollars?

Mr. SWEENEY. Oh, we are talking about $1,800 to $2,500.

Some of the exotic procedures now employed to save these very distressed babies can run as much as $3,500 a day and continue on.

Chairman STARK. And for that you could provide the last few trimesters of reasonably good provision and care?

Mr. SWEENEY. Indeed, sir.

To put the problem in perspective, there were the 3.8 million births in the country last year; 97 percent of those babies, thank the Lord, would appear to be normal and healthy babies. The cost of their hospital care after birth was less than $700 each.

The other 3 percent of the babies born constitute 47 percent of the cost of caring for all infants.

Science and technology has perhaps gotten ahead of our ability to either finance it, or appreciate and support the value of it.

If I may, sir, I appreciate your concern and your interest. Wouldn't it be nice if we could get kids on Medicare, and I guess it would, and we would support that. If it is a 5-year agenda, the youngster who is now 3 years old will spend more than twice his

present life waiting for that to happen. He would be 8 when it came.

In many conditions in children, you need to move to meet that need at the time that it first manifests itself. And there are some things we can do immediately without marked cost to the Federal Government to plug some of the gaps that we have. Your H.R. 2300 is a magnificent initiative.

We would invite you also to consider the requirement that all employers must furnish the minimum of health insurance benefits. And to look at the responsibility of parents. It is surprising to see that there are parents whose incomes are above $20,000 and $30,000 a year, where the parent will be covered by a health insurance policy and the children aren't. Maybe we need a little adjustment of personal values that the committee could foster through some adjustments to the Tax Code.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Nothing.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you.

Ms. Rosenbaum, do you think that our priorities of allocating scarce health resources are out of whack with respect to people's ages? Do you think we should concern ourselves more with need and less with age as we distribute our public resources, whatever they are, to people with health problems?

Ms. ROSENBAUM. Well, fortunately, I think children are much cheaper to care for than the elderly. The figure of $4,400 for the elderly compares to about $500 or $600 for children under Medicaid, and that's the way it should be. Luckily most children need very little health care.

So I don't know that the issue is whether our dollar level expenditures are out of whack as much as that relatively speaking we have simply not made the kinds of investments in all the populations that we need to make.

We do have questions about the continued wisdom of having a major segment in the American population, that is families with incomes well above even 200 percent of the Federal poverty level, who receive virtually all of their health insurance coverage for nothing through a completely employer paid plan while there are Americans who are poor and near poor who have neither the employer paid plan nor the resources to get into a plan if it is offered.

If I were going to target areas of inequity now, I think that would be the first target.

Mr. MOODY. You are talking about employer paid plans. I would like you to focus on just government resources. Let me make two points.

One is that you said that children are much cheaper to take care of, which absolutely is true, and the other corollary is that you get much more health care for the dollar by investing in a child, than you do someone who is 85.

So it is a high return investment if you want to look at it in investment terms.

Ms. ROSENBAUM. Right. Right.

Mr. MOODY. I will repeat my question. If, on terms of public resources, not employer resources, but Government resources, do we

need to reallocate in any way the current mix of our scarce health care resources by age groups?

Ms. ROSENBAUM. The reason I raised employer paid plans is that because Alan Enthoven has estimated that the Federal Government alone loses about $50 billion annually in tax revenues because employer paid insurance premiums are nontaxable.

And so, in thinking about children's policy, we look at both tax expenditures and direct expenditures. And in my opinion, there's no question that neither through tax expenditures nor through direct expenditures has this Government invested adequately in the health of its children. It would be very inexpensive to do so. As I indicated, it would cost relatively little to close children's health care gap, not because there are very few children who are affected. Indeed, there are millions of children who need assistance. But children are relatively inexpensive, and as you have pointed out, it not only is inexpensive to bring their health care access up to an adequate standard, but the return to the nation is fantastic.

You really cannot have a work force 25 years from now comprised of children many of whom began their lives as unhealthily as they are right now and expect to have the kind of taxpaying and governmental supports back from the child population that we are all going to need.

So I think it is not just a matter of children staying well for a little bit of money, but the country staying well for a little bit of money.

Mr. MOODY. The answer to my question is yes.

Ms. ROSENBAUM. We need to invest more.

Mr. MOODY. So the allocation is out of whack in the sense that we have not distributed—those scarce public resources—across age groups in a way to maximize the benefit to the nation.

Ms. ROSENBAUM. I think we simply distributed less, relatively speaking at this point, less to children than they need compared to the amount we have distributed to other age groups. However, it is difficult to say because the other age groups' dollar needs are so much greater.

Mr. MOODY. Do you want to give me your thoughts for a second on the moral justification of spending money on people merely because they are elderly as opposed to being in any other age bracket?

Ms. ROSENBAUM. Well, I began life as a legal services attorney for the aged. I spent a lot of my early years as a lawyer appalled at the conditions under which many of my clients lived.

Many of them were elderly people who as young had had inadequate health care. I frequently had clients who were in their forties and fifties, but who appeared to be in their seventies and eighties.

I think that what is immoral about the health care system right now is that we have a health care allocation plan, whether it's for the young or the old, that is not related to economic need or medical need. It's related to where the person happens to work. It's related to where the person happens to live. It's related to the color of the person's skin. It's related to the person's ethnic background. It is not related to their need and ability to pay. And I think that that is unfair across age groups.

Mr. MOODY. If we had to reallocate between age groups in order to be more target efficient so that we would meet the need more directly, would you have any suggestions how we might do that—if there is only a fixed amount of medical resources in any given time?

Ms. ROSENBAUM. Well, I think the way we do that is to provide health care subsidies in proportion to people's ability to finance their own care. And, therefore, we would look to subsidization methods for all age groups that are most in keeping with their ability to contribute to the cost of their own care.

There are segments of the American population that can contribute, as Bob has mentioned, such as upper income families that, for whatever reason, have not bought dependent coverage for their children. There are a few of them. Fortunately, not too many, but some.

And there are upper income elderly families who do not need completely subsidized care but could, for example, pay perhaps a higher income tax to underwrite the cost of their care.

I think our chief concern is simply with inequity by income status rather than by age status. And because we have evolved a health financing system that depends on where one is employed in this country, which we have serious problems with——

Mr. MOODY. Or if one is employed.

Ms. ROSENBAUM. Or if one is employed. That has led to grave inequities that extend through old age.

Mr. MOODY. Right. But if we focus for a minute on two age extremes, two dependency periods of life, before 18 roughly and then over some age, 65 or whatever. We look at those end points in life when one is in the most dependent status.

Do you think we are out of bounds on how we allocate our resources? I guess that is what I am trying to get at.

Ms. ROSENBAUM. It is so hard to say, because when is the last year of life? Bob can give you an example of a thousand children who at the age of 2 months were in their last year of life. And we spent a lot of money on them. They are not different really from people who are 85 years old. We never know when the last year of life will occur.

So it is a little bit difficult to make allocations on an age basis. We may raise medical technology questions or, as I have said, economic questions. But I think the age distinction is not a fruitful path to follow. I am not sure that it yields us the kinds of answers we need to reallocate scarce resources.

Mr. MOODY. Well, I didn't want to get off into the last year of life issue or those extraordinary expenses at the end of anybody's life obviously. And that can happen at any age.

Ms. ROSENBAUM. Right.

Mr. MOODY. But, of course, the life expectancy of a young patient is usually far greater than that of an old patient.

It just bothers me that we are so neglectful of the children in terms of health care.

Ms. ROSENBAUM. It bothers me.

Mr. MOODY. Just because they are young. Because if they were that same person 60 years later, we would be much more con-

cerned. And that seems to be an inequity. That is just my own personal opinion.

I thought I was looking for some resonance from you on that.

Ms. ROSENBAUM. Well, it bothers us terribly that not all children have access to health care. And we think that this country can well afford it without, in fact, in any way impinging on legitimate income necessities of the elderly.

Mr. MOODY. Thank you.

Chairman STARK. Mr. Daub.

Mr. DAUB. Should we tax the health benefit of a person who has a provided benefit through their employment? Should we tax the fringe benefit we call employer provided health insurance? That is a new source of revenue, right, as opposed to tax on State and local workers who aren't currently paying into the Social Security program, or an earmarked part of a cigarette tax, or a wine, beer and alcohol tax. Why don't we just tax the health benefit that young people are lucky enough to have? Would you agree that we should do that? That could be a new source of revenue which could put some equity into the whole system.

Mr. SWEENEY. Well, there's no question that that could be very tempting as a source of revenue. And then hopefully the resulting revenues could be redistributed within health care needs as opposed to perhaps B-1 bombers.

But I think there's some reverse English on that also. I guess any such proposal would certainly draw a lot of attention.

More importantly, I think it would tend to cause the employee, particularly the lower income level employee, to want to cut back on the coverage that he would have so he would have less tax exposure. That could have a negative effect, particularly employees with dependents.

And in our proposal this morning we have addressed that issue, where dependents are not covered, this occurs most frequently in the lower income level situation where the employee just can't afford to pony up himself the cost of covering his dependents. And frequently these group insurance plans, employer sponsored group insurance plans, will provide the insurance for the worker, but then it is up to the worker to provide for his children.

We want to see that turned around. We want to see the children covered so that they can have needed necessary health care services available without the impediment of there being no resources.

Your proposal might drive that the other way, and might encourage more employees, particularly lower level employees, to remove coverage from their dependents rather than add it.

Ms. ROSENBAUM. I think that if you set the threshold for tax exposure at perhaps a different level from the level that we use for straight income taxes, and if you allow a certain amount of employer paid insurance to be tax free in order to guard against downward notching, there is no reason not to examine the possibility of a tax on disproportionately generous plans enjoyed by upper income employees.

I think that it is an important source of income. I don't know how much income it would yield once certain safeguards were built into the system. But certainly if the Enthoven figures are to be believed, I was shocked. And what he points to, among other things,

are the facts that not only do upper income employees have free benefits but that under ERISA self-funded plans even escape, of course, the premium tax system at the State level that might be used for pooling arrangements.

Mr. DAUB. Another idea. Now, I don't subscribe to the taxing of the employee fringe benefits, to be perfectly clear, nor would I subscribe to this idea. What if we had a national sales tax, some kind of a value added tax at some point in the future? I assume most Members of Congress would want to exempt food and perhaps shelter—would we exempt health care, or might that be a debatable point? Should we put a sales tax on health care?

I think we are trying to talk about ideas. It's easy, as we know on this committee, to talk about all the wonderful ways of doing things, and we all have a good deal of compassion. But we certainly want to see what we can do, and then everybody comes to us for the means to pay for it. And we have to kind of explore in a specific way, not just generally what's good to do, but how to pay for it.

What if we had a national sales tax? Should health care be exempted or included?

Ms. ROSENBAUM. Before we have a national sales tax, there are other more progressive means of raising tax revenues. I think a sales tax may be the least attractive of all means of taxing Americans to try and generate revenues.

Certainly Florida imposes the equivalent of a sales tax on hospital beds right now. I haven't seen the latest profit statements from Florida hospitals. But I don't think they have fared badly. Florida's plan has other problems in how well or poorly it has distributed back to the health care providers the proceeds from that tax.

But, inherently the bed tax was a means of getting around the ERISA problem. The more direct issue was what do we do about ERISA rather than a sales tax on hospital beds.

Mr. DAUB. What role do each of you see private insurance playing in this world of delivery of health care to people under age 65? I mean is there a place for private insurance any more or shall we just federalize the whole thing? What is your specific view, each of you, if you would, for the record?

Mr. SWEENEY. Well, my view is perhaps just at the pragmatic level that the private health insurance is very pervasive. Seventy percent of the children in this country are covered by private insurance.

Mr. DAUB. That many?

Mr. SWEENEY. Yes, sir. Now, that doesn't speak to the quality of that coverage. And that's why we are so encouraged to see Mr. Gradison and Mr. Stark moving ahead on their catastrophic proposal requiring catastrophic coverage in such plans.

But it is a fact that the vast majority of the children are covered by some form of private insurance now.

If I could speak a moment to the Florida tax, tax on hospital revenues—Massachusetts has a similar system in order to fund unreimbursed care.

If I were a major employer in Florida or in Massachusetts who provided my employees with a good health care benefit package——

Mr. DAUB. Which is tax deductible.

Mr. SWEENEY. Which is tax deductible. But then I get taxed again. In effect, that tax is built into the premiums I pay, that tax on the hospitals. I would feel a little uneasy about the fact that I was giving some of my compatriots in the business world a free ride where they are not providing health benefits to their employees. I am providing health benefits for my employees and also taxed on the hospital utilization portion of those benefits.

I think we can look hard at that question of those employers who, at this point in time, have not reached the social consciousness level to provide employees at least the minimum package of health insurance.

Mr. DAUB. Last question, if you care to comment, and that would be should we federally preempt insurance standards? Should we, in health, life, and accident insurance, get over this parochial States' rights view and repeal McCarron-Ferguson, and set all the standards for these things at the Federal level?

Mr. SWEENEY. My experience has been that there are some pretty bright folks out there in the States, in the insurance commissioner's office and elsewhere. They are much more able to respond to local needs and local situations.

I personally don't see that need unless——

Mr. DAUB. Mr. Gradison's bill will mandate federally the standards that for certain kind of catastrophic care now that you are endorsing.

Mr. SWEENEY. As I understand Mr. Gradison's bill, he is not trespassing on the prerogatives of the State insurance commissioners. All he is saying to the employers, if you want to take this off as a business expense, you had better have catastrophic coverage.

Now, the employer——

Mr. DAUB. That preemption is okay. We say no tax deduction if you don't provide this kind of coverage.

Mr. SWEENEY. Well, when I see a lot of young families in our institutions with little babies that can cost anywhere from $25,000 to $250,000 for their care, young families in the formative stage of their lives, and this proposal is going to come along and assist them with that terrible economic burden, I would say, yes, sir, I am all for it.

Mr. DAUB. I appreciate your answer, sir.

I'm sorry.

Ms. ROSENBAUM. Absolutely.

Mr. DAUB. Thanks.

Mr. Chairman, I appreciate the opportunity to examine two very good witnesses who have contributed a lot to our record, and we appreciate your being here.

Thank you.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

I just have a couple of questions.

Ms. Rosenbaum, in response to Mr. Moody's question, did I hear you say that you favor the system of means testing or income relating Medicare?

Ms. ROSENBAUM. I don't think the issue necessarily has to be a means test to Medicare itself. I have never quite understood each time the debate gets framed that way.

I think that upper income, Americans, whether they were 72 years old or 41 years old, should pay a higher income tax. If that money were dedicated in the case of upper income elderly back toward underwriting the cost of their Medicare benefits, that also would be acceptable to us.

Rather than putting a tax on the actuarial value of the Medicare benefit itself, perhaps you might want to slightly increase the tax rate for upper income aged just as you would want to increase the tax exposure for upper income younger Americans perhaps as a way to finance care for all Americans.

I do not consider that means testing Medicare. I consider that simply taxing Americans in greater proportion to their ability to pay.

Mr. DONNELLY. What do you consider to be upper income? Can you quantify that?

Ms. ROSENBAUM. Not being a tax expert, I would have to say from my vantage point it's one of those questions of knowing it when I see it.

For example, speaking for myself, I would consider my husband and myself upper income Americans. Our income is roughly five times to seven times the Federal poverty level for a family of three.

If somebody said me, Ms. Rosenbaum, you may no longer have $3,300 worth of health insurance free, and we are going to treat $600 or $800 of the amount that my employer is paying for my insurance as a taxable event so that I paid an extra amount in income taxes, this would not be unfair.

And if you then told me that that amount was going to go to help someone whose income was my exact tax money at the Federal poverty level or below, to buy him or her medical care, I would say fine.

Mr. DONNELLY. The issue is that we have an enormous amount of health care needs on our plate with an enormous cost with very limited ways to pay for them unless you make substantial changes in last year's tax reform bill.

I guess the point that I am getting to is that it is almost a fact that we will have to relate some ability to pay into our health care system so that we can take care of all those needs——

Ms. ROSENBAUM. Exactly.

Mr. DONNELLY [continuing]. Without the Medicare program continuing to just expand on a random basis.

Now, one of the potential problems with that approach, of course, are the Medicare clients and the organizations that represent them—or claim to represent them—who are insistent that there be no ability to pay put into that Medicare system. And we need to build some sort of consensus around the issue—or at least some flexibility on the part of some folks around the issue—that there are people in this country that aren't receiving basic health care benefits, that aren't receiving the basic health insurance, but there are those that, because of their personal finances and circumstances, are very well protected and that the Government is subsidizing.

Ms. ROSENBAUM. No. But we take exactly the same position. That's why I have stressed that we would take exactly the same position for younger upper income families wherever we ultimately

decide to set the income threshold. The issue of whether well-to-do families in any age bracket should, through a progressive income tax system, contribute in greater proportion toward the cost of the governmental benefits they receive, either through the tax expenditure system or through the direct expenditure system as in the case of Medicare is an issue that I think CDF has developed a clear position on throughout our work on tax reform. We would view this as an extension of the same tax reform discussions. And we make no age distinctions whatsoever on that issue.

Mr. DONNELLY. Mr. Sweeney, what percentage of uncompensated care do the hospitals in your organization provide? The children's hospital.

Mr. SWEENEY. Yes. Yes, sir, and if you will grant me a basic premise that State Medicaid programs are basically marginal payers, then the uncompensated care in children's hospitals can run anywhere from 10 to 15 percent of total revenues.

Around the country we have many situations where the Medicaid programs do not meet even cost of providing services to children. They limit the number of days of care for which they will pay, or they will limit the payment. And, of course, under the law, there is no other recourse for the institution. They are not allowed to seek payment from those patients.

So, on the basis that Medicaid is frequently a partial payer, the range of uncompensated care is going to run from 10 to 15 percent. In a slogan that was used a year ago, we talked about disproportionate share. Children's hospitals' disproportionate share equals that of the public hospitals—35 percent of their patients are from the so-called disproportionate care category.

Mr. DONNELLY. But you're running on a nationwide average between 10 and 15 percent?

Mr. SWEENEY. Yes, sir. I will verify that figure, and if I'm off, I will correct it.

Mr. DONNELLY. I would appreciate that. It was substantially higher than the national average for all other hospitals.

Mr. SWEENEY. Yes.

Children's hospitals, serving a tertiary regional center function, very frequently get the most extreme cases, or they get cases who have gone through a whole course of treatment elsewhere, and then are referred to the tertiary center.

Coincidental to that, any insurance benefits, such as they may have had, may have been used up.

Mr. DONNELLY. Mr. Chairman, we have a real problem dealing with the data on uncompensated care because there are no set national standards. But if you could exclude and take out the children's hospitals and the public hospitals' uncompensated care, I would like, for the record, what the percentage of uncompensated care has been in the last fiscal year provided by all other hospitals within the system. I think that would be an interesting statistic if we could have that for the committee, unless you have it, Mr. Sweeney.

Mr. SWEENEY. Of course, it is a misnomer, Mr. Donnelly. There is no such thing as uncompensated care. There ain't no free lunch. Somebody pays.

Mr. DONNELLY. Yes, I understand that. But at least for the jargon of the Federal bureaucracy.

Mr. SWEENEY. Yes, sir.

[The following was subsequently received:]

Children's Hospitals Disproportionate Share and Uncompensated Care

Source: 1985 AHA Annual Survey of Hospitals
Compilation: NACHRI, March 1986

Disproportionate Share:

Bad Debt & Charity Care (% of Total Charges)	= 6.4%
Medicaid (% of Total Charges)	= 25.6%
Total, Disproportionate Share	= 32.0%

Uncompensated Care:

Bad Debt and Charity Care	= 6.4%
Medicaid Losses*	= 6.9%
Total, Uncompensated Care	= 13.3% of total charges

* Formula for Calculating Medicaid Loss:

- Medicaid payment = 56.7% of hospital charges or 73.0% of hospital costs of care.
- Medicaid activity = 25.6% of total charges.
- Medicaid loss in terms of children's hospitals' costs (not charges) = (100% - 73%) x (25.6%) = 6.9%.

Mr. DONNELLY. Thank you, Mr. Chairman.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

I may be asking something that you have already answered, but if either of you can give me an overall position, I would like to hear it.

Are you recommending catastrophic coverage for everyone under 65 or just women and children? And if so, how would you recommend we pay for it? Are you suggesting to us what the cost will be? Have you all mentioned that, about how you would fund either approach?

Mr. SWEENEY. Sir, as mentioned, of course, there is no Medicare hook on which to hang the solution for children. Children are not presently covered except for those with end stage renal disease.

So our sense is it needs to take a variety of approaches to deal with the catastrophic illness expense needs of children.

First and most directed, is the legislation before this subcommittee, H.R. 2300, which would make available catastrophic coverage for the 70 percent of America's children who are covered by some form of health insurance. Beyond that, we see a definite need for strengthening and leveling up of the various Medicaid programs around the country.

And as you know, Mr. Pickle, in some States Medicaid is better, meets more comprehensively the needs of poor people than it does in other States. So that would move considerably towards protecting those children who are not in the private sector.

Third, working with a coalition of health organizations here in town, we have come up with a proposal that would create a catastrophic fund to be run by the maternal and child health program in the Department of Health and Human Services, with a very high threshold so it does not encourage employers to cut back on their protection, but would help those families who have extreme high cost care, particularly of infants.

Mr. PICKLE. Well, you have discussed some of the needs in the various categories.

Mr. SWEENEY. Yes, sir.

Mr. PICKLE. What do you estimate the cost to be, and how would you pay for it? Are you recommending taxing the value of benefits? Are you recommending shifting the poverty level up or down? What is the poverty line.

How would you get the funds for it?

Mr. SWEENEY. The funds, of course, to add catastrophic protection for the 70 percent of children covered by private sector insurance would generate from the private sector. That would be in effect an added cost of doing business for businesses that now provide insurance benefits for their employees and their dependents.

Mr. PICKLE. Are you recommending that the employers have a health program of their own that they would pay for?

Mr. SWEENEY. Yes, sir. We have further recommended that all employers be required to provide a minimum package of health insurance benefits for their employees.

We are the only industrialized nation in the world that doesn't insist on that, particularly in the case of children. And it's interesting to note for those who say such proposals will make us noncom-

petitive in international trade; it's the very nations with which we are having the difficulty in international trade which have required this sort of protection for their children for years. Maybe they have healthier workers as a result. Maybe that's why they can compete more effectively.

Mr. PICKLE. You may be right.

Mr. SWEENEY. Yes, sir.

Mr. PICKLE. Who knows? I am trying to get at what you are recommending and the cost involved.

Do you have anything to add to?

Ms. ROSENBAUM. No, other than to underscore that because of the pluralistic nature of financing for younger families, there are going to have to be pluralistic revenue sources and remedies so that the employer protections that H.R. 2300 embodies would be paid for by employers, and they would get, of course, a tax deduction. We would pay out some tax dollars I assume for the added benefit.

We think that when it comes to enhancements in public programs for individuals who don't have access to employer provided insurance, we need to look to both general revenues and some new source of revenues. And one new source of revenues might be a small tax on some portion of that portion of the employee's health insurance benefit than an employer pays. That's not so much taxing the value of the benefit as taxing income that passes from the employer to the employee, but never shows up in the employee's pocket because it goes directly toward the purchase of health insurance.

If some small portion of that income were made a taxable event for upper income employees, it might well yield enough money to make some of the public insurance improvements we need, as well as offset the lost tax dollars through improvements in employer coverage.

Mr. PICKLE. One approach you would take would be to tax the value of benefits similar to the approach this committee had for financing the present catastrophic bill which we decided against. But you would go back into that area to a limited extent?

Ms. ROSENBAUM. Yes. And again I don't, considering that taxing the value of the benefit as much as taxing some of the income that goes into securing the benefits.

In the case of younger workers, younger people who are upper income, it is clear where those dollars are. In the case of older Americans, it may mean a slightly higher income tax for upper income aged persons.

Mr. PICKLE. I thank you, Mr. Chairman.

Mr. DONNELLY [presiding]. Mr. Chandler?

Mr. CHANDLER. Thank you, Mr. Chairman.

I have no questions for the panel of witnesses here, and I thank them for their testimony. I think I do understand their position.

If I could, Mr. Chairman, I would like to insert into the record a question for Mr. Crandall, from American Airlines. I, unfortunately, could not be here for this testimony. The staff has indicated that they would send those questions to him and he could respond for the record.

Mr. DONNELLY. Without objection.

Mr. CHANDLER. The presentation that Mr. Crandall made said that he would approve or would like to require employers to provide basic health benefits for all employees and retirees. The suggestion is, he says, not so much one of compassion or concern for health needs but one of competition between airlines, which I find to be rather interesting. And he says that from a point of view of a competitor of Continental Airlines, which is a subsidiary of Texas Air, he says they used bankruptcy to reduce their labor costs in half, and quoting him, "You don't have to be a business genius to figure out that when a company has labor costs twice that of a larger competitor something has to give."

We may at some time find that we need to mandate health insurance benefits for employers. I am ready to concede that. However, I am wondering if Mr. Crandall isn't suggesting something here that could lead eventually to more than what I think he has in mind. For example, what would be the effect on the health of Texas Air and its ability, not just to compete, but to survive, if the Congress of the United States required not just minimum health benefits but retiree health benefits?

[The response follows:]

If Texas Air were to be required to provide basic health benefits for its employees and retirees, there would be no adverse impact on the health of that company, nor on its ability to compete or survive. The reason is that other airlines already provide those benefits, so Texas Air would not be placed at any competitive disadvantage.

Mr. CHANDLER. Second, is it not the case that when one company's compensation package is superior to another's that that company then has an advantage when it comes to attracting quality employees, which then would, in turn, provide them with superior service and a competitive advantage? It doesn't seem to me that price is everything here.

[The response follows:]

It is true that companies with an enlightened approach to basic health benefits can attract higher quality employees than companies that place a lower priority on employee health. It is also true that higher quality employees provide superior service. You should not, however, underestimate the power of low prices. Eastern Airlines' load factor—the percentage of seats that are sold—continues to compare favorably with the industry average despite that company's repressive policies with respect to employee wages and benefits.

Mr. CHANDLER. Also, if we find that by mandating employer health benefits and retiree health benefits that we have now made Continental's wage or labor costs a quarter or three-fourths of what American's is, then should we go the rest of the way and mandate that they raise salaries to the same level, so that there would be this perfect level of competition?

I am being rhetorical here, I realize, and perhaps even argumentative. But I think that if all that is involved here is competition between airlines and that mandating health benefits for workers and retirees is simply intended to bring about greater or more level playing fields, then I think we are heading down the wrong path.

If it will result in superior health care for the employees of both those airlines, then I am willing to think about it; but not on the basis of trying to bring about competition between those in the marketplace who if they really took one another on, might well do

better than to have the Congress get involved in making them competitive.

[The response follows:]

In my mind, there is a vast difference between mandating basic health benefits and trying to achieve perfect cost parity in other areas. Competition is not all that is involved here. We are talking about the need of every person in the United States for basic health care and about the best way to provide it, which I think is via private sector, employer-sponsored plans. The competitive issue arises here because companies that provide these very expensive benefits have no choice but to consider eliminating them if that is the only way to remain cost competitive with companies that place a low priority on employee welfare.

Chairman STARK. Any other members care to inquire? If not, I want to thank the panel very much for their help today.

Our final witness is Mr. Robert Patricelli, the chairman of the Health Care Council, the United States Chamber of Commerce.

Welcome to the committee, Mr. Patricelli. You may proceed in any manner that you are comfortable.

STATEMENT OF ROBERT E. PATRICELLI, CHAIRMAN, HEALTH CARE COUNCIL, UNITED STATES CHAMBER OF COMMERCE, ACCOMPANIED BY JAMES A. KLEIN, MANAGER, PENSION AND EMPLOYEE BENEFITS

Mr. PATRICELLI. Thank you, Mr. Chairman, and members of the committee. I am Bob Patricelli. I am here representing the U.S. Chamber of Commerce Health Care Council today, which I share, and I think it is relevant to note that I, personally, in the past had numerous involvements with health policy and health business in both the Federal Government and the private sector. I am joined today by Jim Klein, the manager of pension and employee benefits for the chamber.

My purpose, Mr. Chairman, is to be constructive today and try to be helpful to this committee, and I am prepared to discuss broadly the issue of mandates with you should that be your interest. But let me at this point summarize, I hope briefly in a few points, my testimony, which I hope you have had the opportunity to read. I will do this in just seven points.

First, catastrophic insurance is clearly desirable. Indeed, it is probably the best function of insurance, to protect against last-dollar as opposed to first-dollar-type costs.

Second, our private employer-based system has been moving rapidly to incorporate catastrophic-type coverage through stop-loss features. In 1984, 91 percent of covered employees had coverage as good as that presented by this bill, up from 79 percent since just 1980. So the number is probably well over 91 percent by now.

Third, it is therefore tempting to say let us plug this last little gap, and surely it wouldn't be very expensive; surely, if necessary, it could be offset in other ways within the employer's benefit plan; and with the bill's exclusion of employers with less than 20 employees, it wouldn't affect that many employers anyway, so why don't we just plug it?

Fourth, why, then, is the chamber prepared to oppose this bill? The answer to that is because Congress is starting down the same road now that the States have trod in erecting an array of benefit mandates in a manner I believe that is costly, duplicative, and re-

flective of piecemeal policy making. And I want to take these points separately.

The fifth point is that mandates are costly. There are now 640 of them roughly at the State level, some of which, by the way, do mandate catastrophic coverage. For a multistate employer, this presents an expensive administrative burden and within any one State for a smaller employer, we have now the catch-22 effect of discouraging employers, particularly small employers, from carrying insurance at all since all of these benefit mandates raise the price to play.

And studies have shown that the actual cost of treatment in mandated benefit categories is higher in States with such mandates than in States without. Costs cannot be ignored. Labor costs are an important factor in terms of job creation and in the international competitiveness of this country.

Sixth, Federal mandates at this time would be duplicative. States regulate insurance, not the Federal Government; and you already have a tremendous array of State benefit mandates. Are we now to replay the same scenario at the Federal level with a system of overlapping mandates as the Congress develops a special affection for one or another particular piece of benefit planning? Are we to develop a system of what amounts to Federal minimums for State benefit mandates?

And this gets me to the seventh and the last point: What is our policy? What is our health care financing policy? Is it a Federal or State system of regulating insurance? Who will regulate HMOs? Who will regulate PPOs? What about ERISA? The Congress exempted self-insured plans from State mandates and the curious result is that these State mandates produce costs and complexity that now falls most heavily on small employers. Those very employers who should be encouraged, not discouraged from offering coverage.

So, Mr. Chairman, I urge you not to go farther down this piecemeal road and using riders to "must" bills to get enacted individual Federal benefit mandates, but instead to launch a full-scale review of the issues surrounding the uninsured and the under insured in the workplace and the concomitant issues of gaps in the coverage of the Medicaid program.

The chamber is doing this itself and has launched such a study of gaps in coverage, and we would be very pleased to join you in supporting such an effort by the Congress.

Thank you.

[The prepared statement follows:]

STATEMENT
on
CATASTROPHIC ILLNESS PROTECTION FOR
THE POPULATION UNDER AGE 65
before the
SUBCOMMITTEE ON HEALTH
of the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
Robert E. Patricelli
May 12, 1987

Mr. Chairman and members of the subcommittee, my name is Robert E. Patricelli. I am President of ValueCare, Inc., a managed health care company, headquartered in Connecticut. It is also relevant to note that in the past I have served as head of CIGNA Corporation's health care companies and as Deputy Under Secretary of the U.S. Department of Health, Education and Welfare from 1970 - 1971. I am also Chairman of the U.S. Chamber of Commerce's Health Care Council, and I am pleased to appear here today on behalf of the Chamber to discuss catastrophic illness protection for the population under age 65 and, specifically, the "Catastrophic Illness Expense Protection Amendments of 1987" (H.R. 2300). Accompanying me is James A. Klein, Manager, Pension and Employee Benefits for the Chamber.

In brief, the Chamber supports the present system of voluntary, nondiscriminatory, private-sector employee health care benefit plans, which can vary in accordance with the needs of employers and employees. We oppose federal or state government requirements mandating plan design or financing, whether applicable to insured or self-insured plans, because they limit flexibility and raise costs. Furthermore, if Congress decides to embark on a departure from this system, fairness to all affected parties demands that there first be a thorough policy debate with the objective of avoiding piecemeal mandates and the doubling-up of federal and state requirement.

The Success of the Voluntary Health Care Financing System

American businesses provide health care coverage to 132 million people, which represents 84 percent of the total private health care coverage in the nation. In 1985, the total health care expenditures of American businesses was $105 billion. That amount does not include the additional portion of public health expenditures that businesses, as taxpayers, helped to finance. This privately financed health benefits system has permitted Amerian health care to become the best in the world -- driven by pluralistic and competitive forces rather than being constrained by the regulation and bureaucracy of national health insurance.

In recent years, there has been increased attention paid to the real problem faced by millions of Americans who lack health care coverage under this privately financed system. The Employee Benefit Research Institute reports that of the approximately 35 million Americans without health care coverage perhaps 19 million are people who hold jobs and several million more are the dependents of workers. This problem is especially true within the small business sector. The U.S. Small Business Administration reported that in 1983, 39 percent of businesses with fewer than 25 employees had health coverage, compared to 85 percent of firms with more than 500 employees.

The Chamber shares this growing national concern over the uninsured and is committed to finding ways to extend private, voluntary coverage without, at the same time, so increasing labor costs that jobs are lost.

The issue of catastrophic illness expense protection for individuals under age 65, as addressed by H.R. 2300, does not, however, deal with the "uninsured" population. Rather, it relates to the "underinsured"--those who have some employer-provided health coverage, but not a certain level of catastrophic protection. The provisions of H.R. 2300 do not require a company to offer health care coverage. However, if the bill is enacted, any business over a certain size that does offer coverage would have to provide a prescribed catastrophic protection feature in order for the firm's health care expenses to be deductible. With this bill, along with the COBRA provisions enacted in 1985, the Congress threatens to start down a road of benefit mandates already well trod by the states.

82-404 O - 88 - 3

The Growth of State-Mandated Benefits

Decades of legislation and case law have clearly established that insurance is regulated at the state, not federal, level. Historically, various groups have advocated minimum requirements for benefit levels, elements of coverage, or rules for reimbursement for particular categories of health care providers.

Under this pressure, all states have enacted mandated health benefit provisions. Typically, these mandates include extensions of eligibility for coverage to various classes of beneficiaries, or requirements for health plans to cover treatment for alcoholism, drug abuse, or mental problems, or reimbursement for treatment by particular health professionals. These state mandates now number well over 600. A chart listing the various state mandated benefits is shown in the appendix to this statement.

The proliferation of state mandated laws has undoubtedly raised health care costs for businesses. Indeed, state mandated benefits have encouraged many companies to self-insure in order to gain the protection of the Employee Retirement Income Security Act of 1974 (ERISA) against these mandated costs. Regrettably, small employers, which are not able to assume the risks inherent in self-insuring, face higher health care expenses in providing coverage through traditional insurance products. This exacerbates the problems smaller companies face in providing coverage to their employees.

The excessive burdens imposed by mandated benefits have led at least five states, Arizona, Nebraska, Oregon, Pennsylvania, and Washington, to adopt benefit evaluation mechanisms to assess the cost/benefit trade-offs of state mandated health benefits.

The Growth of Federally Mandated Benefits

Until very recently, the trend toward mandated health benefits remained largely a state law phenomenon. For decades, the only benefits that employers were required by federal law to provide were Social Security, unemployment insurance, and workers' compensation. Indeed, the philosophy of ERISA was to preempt state mandates and to avoid erecting federal requirements in their place.

That philosophy began to change with the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which contained provisions requiring employers to continue to make available health care plans to various categories of former employees and their family members for periods ranging from 18 to 36 months. Those "continuation of coverage" provisions were attached to the reconciliation measure with virtually no Congressional discussion.

Although the continuation of coverage under COBRA is made available at the beneficiary's own expense, simply complying with COBRA is an administrative burden for many companies. Moreover, the likelihood that those individuals who are the most frequent users of health care coverage will be the most likely to continue that coverage--with the commensurate increase in insurance premiums due to the adverse selection--belies the claim that COBRA involves no cost to employers. The fact is COBRA and other federal cost-shifting to business have been a powerful incentive for companies to discontinue or reduce health care or other employee benefits.

H.R. 2300

Now, the business community is faced with the worst-case scenario: imposition of both state and federal piecemeal mandates. Despite assurances to the contrary, H.R. 2300 is a mandated benefit measure for all practical purposes. If a company wants to provide health care coverage to its employees on a tax deductible basis (and, as we noted earlier, most companies do), a prescribed level of catastrophic coverage must be included.

As a practical matter, most employers offering health coverage already are providing the level of catastrophic protection sought under H.R. 2300. The Health Insurance Association of America reports that in 1984, 91 percent of the individuals covered by commercial health plans had employee expense limits of $2,000 or less. That percentage is up from 79 percent of the covered individuals in 1980.

It seems fair for the business community to question the need for legislation when most employees with health coverage protection already have the protection targeted by this bill. One can assume that at least some of the employees who do not have a limit of $2,000 for out-of-pocket expenses do have some catastrophic coverage but with a higher stop-loss level. One can also assume that at least some have more generous benefits in some other respect. Clearly, some employees with health care coverage do not have any catastrophic coverage. However, the previously cited Health Insurance Association of America data shows that that group is small and getting smaller. A federal mandate hardly seems called for to solve the remaining problem, especially since the exclusion of firms with fewer than 20 employees probably exempts most of the underinsured without catastrophic coverage.

Our objection to this bill lies not primarily in its direct economic impact, since relatively few businesses would be affected and its cost could be absorbed through reductions of other benefits where needed. Rather, we are concerned because the bill follows the precedent of COBRA and sets the stage for a system of federally-dictated health plan provisions that overlap already burdensome state directives. We have seen other recent evidence of this trend. Before COBRA even went into effect last year, the Access to Health Care Act legislation, H.R. 4742, was introduced, and this subcommittee held a hearing on the bill which would have required business directly to pay for four months of health coverage for former employees. That bill also would have directed the states to establish risk pools for the medically uninsurable population, which would have been subsidized, in part, by employers. The Chamber is very concerned about this piecemeal approach of federal restrictions on health plans, which are not being considered against the broader background of costly state mandated requirements.

Frankly, Congress is starting down a track of federalizing health insurance regulation and defining a mandated private national health insurance plan. If that is the logical end point of this trend, let us confront and debate it now, rather than getting there piecemeal.

Finally, with regard to H.R. 2300, we note a great deal of concern with the possible process by which the bill may be considered. The remarks accompanying the introduction of the bill indicated that the intent of the sponsors is to find an appropriate legislative vehicle to which H.R. 2300 can be attached. This suggests that once again an important employee benefits measure will become an appendage to a more comprehensive bill, such as a budget reconciliation measure. While we commend the subcommittee for holding hearings on this bill today, we must state the Chamber's categorical opposition to this measure being included in some general, comprehensive legislation. Such a procedure does not permit the deliberate, considered judgment of Congress to be brought to bear on an important health policy matter.

One of the biggest objections to COBRA that the Chamber has heard from its members was that their ability to affect the decision of their member of Congress on the issue was thwarted by the manner in which the measure was considered.

If the purpose of H.R. 2300 is important enough to enact into law, then we believe that it is important enough to have a separate mark-up by the full Committee on Ways and Means and the Committee on Finance and separate votes in both houses of Congress, so that lawmakers and the public both are aware of what is being considered.

Alternative Methods to Expand Catastrophic Illness Expense Protection

While the Chamber is concerned about the method of extending catastrophic coverage suggested by H.R. 2300, we share the subcommittee's concern over the lack of this type of coverage for many Americans. Accordingly, we suggest a few alternatives.

First, for the population under age 65 that has employer-sponsored health coverage, but not catastrophic coverage, there is a need for the insurance industry to work more aggressively to offer insurance products that will close that small but very real gap in coverage. For example, with better education on the importance of catastrophic expense protection, employers and employees may be encouraged to forego other less critical forms of coverage in favor of catastrophic protection, without making the coverage too expensive for the employer to offer.

Second, for the working population without any health coverage, renewed consideration must be given on how to provide protection against the most catastrophic financial expenses. One alternative might be a limited preemption of state mandated benefit laws that would permit insurance products to be sold that would provide just catastrophic coverage or basic coverage plus a catastrophic feature--and not the spate of other benefits required by states. Such an insurance policy likely could be considerably more affordable and substantially increase the likelihood that businesses not currently providing coverage to employees might begin to do so.

Third, individuals who choose to forego health coverage must be educated about the importance of obtaining it either through individual insurance policies or from employers where it is available. For example, younger individuals, such as college students or those entering the work force, may not perceive a need for health coverage because of their excellent health. They must be encouraged to obtain it, if they are able to do so.

Finally, as always, there is a proper role for the public sector in meeting the needs of those who are not covered either by employers or under the options described above. Our health care system is a private/public partnership. The Chamber strongly supports the private-sector approach to financing and providing health care wherever possible. However, where private-sector coverage is not practical--such as for the unemployed population--all of us as citizens share the responsibility for ensuring access for the neediest. In the Chamber's perspective, adequate, but not excessive, expenditures on public programs are preferable to inequitable cost-shifting to the business community that is already providing a substantial portion of catastrophic protection.

Conclusion

Mandates at the federal and state level are costly and impede the flexibility that is needed to allow employers and employees to tailor a health plan that best serves their needs. A variety of options exists to encourage the expansion of catastrophic expense protection for those with some health care coverage and those lacking any coverage. Encouraging greater flexibility in the types of coverage that can be offered--rather than imposing restrictions on such coverage--is most likely to expand employer-sponsored coverage.

The Chamber stands ready to assist the subcommittee in addressing the very important issue of catastrophic coverage for Americans of all ages.

APPENDIX

STATE MANDATED HEALTH CARE COVERAGE LAWS

(ENACTED THROUGH DECEMBER, 1986)

PREPARED BY THE OFFICE OF
GOVERNMENT RELATIONS,
STATE SERVICES DEPARTMENT,
BLUE CROSS AND BLUE SHIELD
ASSOCIATION

CONTACT PERSONS:
GREG SCANDLEN
BRENDA LARSEN
02/10/87

MANDATED COVERAGES

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA
NURSES										
Nurse Midwives		83	85				84		83	
Nurse Practitioners			85				84			
Nurse Anesthetists			85				84			
THERAPISTS										
Physical							75			
Occupational					78		82			
Speech/hearing				85	78					
COUNSELORS										
Psychologists	82		83	75	80	79	75			80
Psychiatric Nurses					82		84			
Social Worker					76		79			
DENTISTS	75	83	77		76		75			
ORAL SURGEONS										
OPTOMETRISTS	67	83			80		75	X*	74	
PODIATRISTS	76			75	76			X*	74	
CHIROPRACTORS	75	83	83		76		71	X*	76/86	80
OSTEOPATHS		83								
OTHER				75	76		75/84			
ALCOHOLISM	79		79		78	76	74/77		79	
DRUG ABUSE			79				76		79	
MENTAL HEALTH			79	83	73	76	75/82		76/83	81/84
BREAST RECONSTRUCTION			81	78	78					
MATERNITY				76	76	75	76			78
PRESCRIPTION DRUGS							75			
ORTHOTIC AND/OR PROSTHETIC DEVICES					85					
CLEFT PALATE										
DIABETIC EDUCATION					81					
DIABETIC OUTPATIENT										
SECOND OPINION										
HOME HEALTH			82		78	84	75/76			
HOSPICE						84	76			
LONG TERM CARE										
AMBULATORY SURGERY			71						77	
ANTI-ABORTION						85	82			
PUBLIC INSTITUTIONS										
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS					74				86	
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							82			79
ADOPTED CHILDREN			85						85	
NEWBORNS	75	75	74	75/83	71	75	74	74	80/84	74
MENTALLY/PHYSICALLY HANDICAPPED			77	69	71		71		70	72
NON-CUSTODIAL CHILDREN							84			
CONVERSION PRIVILEGE			85	79/85	83		75			
CONTINUATION FOR DEPENDENTS			85	85	76		75/76			80/81
CONTINUAT FOR EMPLOYEES				85	77/84	86			75	86
CATASTROPHIC COVERAGE										
MANDATE EVALUATION			85							

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

02/10/87

MANDATED COVERAGES

	MI	ID	IL	IN	IA	KS	KY	LA	ME	MD
NURSES										
Nurse Midwives								84		78
Nurse Practitioners										79
Nurse Anesthetists										84
THERAPISTS										
Physical										
Occupational										
Speech/hearing										
COUNSELORS										
Psychologists	84			85		74		75	75	73
Psychiatric Nurses									83	83
Social Worker						82			83	77
DENTISTS	74			74		73		74	75	
ORAL SURGEONS										
OPTOMETRISTS			80	74	83	73			82	73
PODIATRISTS			81	74		73				73
CHIROPRACTORS				74	86	73	80/86	75	86	73
OSTEOPATHS										73
OTHER			82							
ALCOHOLISM				76		86	78	80	74	82 80
DRUG ABUSE						78/86		80	83	78
MENTAL HEALTH			74/77			78/86	86	75	79/83	73/86
BREAST RECONSTRUCTION			80							
MATERNITY	74								75	75
PRESCRIPTION DRUGS									83	
ORTHOTIC AND/OR PROSTHETIC DEVICES										78
CLEFT PALATE		85		85						82
DIABETIC EDUCATION					84					
DIABETIC OUTPATIENT										
SECOND OPINION										85
HOME HEALTH							82		77	79
HOSPICE										82
LONG TERM CARE							86			
AMBULATORY SURGERY	74						78			
ANTI-ABORTION							78			
PUBLIC INSTITUTIONS										67
AMBULANCE/TRANSPORT FOR NEWBORNS								80		
PREVENTIVE CARE FOR CHILDREN/INFANTS									79	76
OTHER HEALTH CENTERS				85						
DEPENDENT STUDENTS								78		79
ADOPTED CHILDREN			81							79
NEWBORNS	74	74	75	76	74	74	76	73	76	77
MENTALLY/PHYSICALLY HANDICAPPED	68	72	67	69/86				72		X
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE			83		86	78/80	74		82	79
CONTINUATION FOR DEPENDENTS			76/85		86	78/84	80			77
CONTINUATION FOR EMPLOYEES	74	75	84		86	84	80	83	83/86	79
CATASTROPHIC COVERAGE										78
MANDATE EVALUATION										

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

02/10/87

MANDATED COVERAGES

	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ
NURSES								85		84
Nurse Midwives			83	80			84			82
Nurse Practitioners				80					85	
Nurse Anesthetists			83	80						
THERAPISTS										
Physical										75
Occupational										
Speech/hearing					84					
COUNSELORS										
Psychologists	75	68*	75	74	83	81	74	80	75	73
Psychiatric Nurses	86									
Social Worker	82					85			83	
DENTISTS	75		73	74	78	83	75	75		79
ORAL SURGEONS		85							75	
OPTOMETRISTS			73	66	78		69	75		67
PODIATRISTS			73		78		69	75		
CHIROPRACTORS		79	73	80	78		67	82		80
OSTEOPATHS							67	75		
OTHER					78			75		
ALCOHOLISM	73	74/82	73/82	74	77/85	79	80	83		77
DRUG ABUSE		74/82	73/82		80	81		83		
MENTAL HEALTH	73/82		75		80	81			75/83	
BREAST RECONSTRUCTION		85	80					83		83
MATERNITY			73		73			77		
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES		85								
CLEFT PALATE										
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION										80
HOME HEALTH	86					81		75		
HOSPICE		84						83		
LONG TERM CARE										
AMBULATORY SURGERY		84/85	76		75/81					
ANTI-ABORTION					83					
PUBLIC INSTITUTIONS			73			73	84			
AMBULANCE/TRANSPORT FOR NEWBORNS				79						
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							76			
ADOPTED CHILDREN	75		83							
NEWBORNS	74		73	74	74	73	75	76	75	75
MENTALLY/PHYSICALLY HANDICAPPED	56	66	69	72		71		76	69	66
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	76		77		81	81	78	80		
CONTINUATION FOR DEPENDENTS			73/77		69		80	80	81	76/80
CONTINUATION FOR EMPLOYEES			73		85	81	79			82
CATASTROPHIC COVERAGE			76							
MANDATE EVALUATION							86			

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

02/10/87

MANDATED COVERAGES

	NH	NY	NC	ND	OH	OK	OR	PA	RI	SC
NURSES		**84**						86		
Nurse Midwives	85	82			84	71		82		
Nurse Practitioners				**86**			80	86		
Nurse Anesthetists								86		
THERAPISTS										
Physical		73								
Occupational										
Speech/hearing										
COUNSELORS										
Psychologists	77	71	77		74	71	76	78		
Psychiatric Nurses										
Social Worker		82								
DENTISTS	77	75			73	71	71			
ORAL SURGEONS										
OPTOMETRISTS	77	X			80	71	76	78		85
PODIATRISTS	77	X			80	71				72
CHIROPRACTORS	84	X	73	79	80	71		81		80
OSTEOPATHS	77				80					
OTHER	85									
ALCOHOLISM	**83**	82/83	**84**	75	78		75/81	86	80	
DRUG ABUSE			**84**	75						
MENTAL HEALTH		77		75	83		73			
BREAST RECONSTRUCTION		75								
MATERNITY		76			79		73			
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE			82							
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION		76							83*	
HOME HEALTH	77	72/75							84*	
HOSPICE		85								
LONG TERM CARE										
AMBULATORY SURGERY		X				76				
ANTI-ABORTION				79				82		
PUBLIC INSTITUTIONS			75		76					
AMBULANCE/TRANSPORT FOR NEWBORNS	75									
PREVENTIVE CARE FOR CHILDREN/INFANTS		82								
OTHER HEALTH CENTERS		X								
DEPENDENT STUDENTS										
ADOPTED CHILDREN										
NEWBORNS	75	77	73	79	74	**84**	75	76		74
MENTALLY/PHYSICALLY HANDICAPPED	69	65	69/73	**82**	71			68		70
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	83	71/81	82	83	75/84		77		78	78
CONTINUATION FOR DEPENDENTS	83	81	83						83	78
CONTINUATION FOR EMPLOYEES										
CATASTROPHIC COVERAGE									74	
MANDATE EVALUATION							85	86		

X = Year unknown
* = Commercials only
Bold Print = Mandated offerings

02/10/87

MANDATED COVERAGES

	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
NURSES							81			
Nurse Midwives	80			79			81	83		
Nurse Practitioners	80						81			
Nurse Anesthetists										
THERAPISTS										
Physical										
Occupational										
Speech/hearing			83							
COUNSELORS										
Psychologists	86	74	77	75		77				85
Psychiatric Nurses								77		
Social Worker		85		75		79				
DENTISTS		74	83						75	
ORAL SURGEONS										
OPTOMETRISTS		65	79	75		77			75	
PODIATRISTS		65	77	75		79	83		75	
CHIROPRACTORS		81	79	75		79*	83		76	
OSTEOPATHS			58			77				71
OTHER	80	82				77				
ALCOHOLISM	79	79	81	81	82/85	77/80	74	82	74/85	
DRUG ABUSE			81			77/80			74/85	
MENTAL HEALTH		79/80	81		76	76/77	83	77*	74/86	
BREAST RECONSTRUCTION							83/85			
MATERNITY		84	77			78			82	
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE										
DIABETIC EDUCATION									84	
DIABETIC OUTPATIENT				84					82	
SECOND OPINION										
HOME HEALTH					76		83		78	
HOSPICE							83			
LONG TERM CARE								86		
AMBULATORY SURGERY				76						
ANTI-ABORTION										
PUBLIC INSTITUTIONS									80	75
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS			83						75	
DEPENDENT STUDENTS										
ADOPTED CHILDREN	83			85						
NEWBORNS	76	74	73	77	76	76	74/84	75	76	75
MENTALLY/PHYSICALLY HANDICAPPED		69	81	75		74	69		75	71
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	79	81	77	79		82	84		80	83
CONTINUATION FOR DEPENDENTS	80	84	79		84		80	83	80	
CONTINUATION FOR EMPLOYEES							73	82	73/80	
CATASTROPHIC COVERAGE										
MANDATE EVALUATION							84			

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

02/10/87

MANDATED COVERAGES

Miscellaneous

AR - Outpatient Diagnostic; Licensed Health Professionals (75)

AZ - Maternity benefits for natural mother of an adopted child on adopted parents policy (86)

CA - Sterilization (70); Prenatal Care (76,79); Child/Family Counselors (80,81); Acupuncture (84); Psychiatric Health Facility (84)

CT - Notice of Termination (82); Nutropathic Medicine (75); most passed under comprehensive health care act of 1975; HMO Rehabilitation Facilities (82); Emergency Ambulance Services (83); Home Health Aides; (84) Home Health Aides under Medicare supplement policies (86)

CO - Anti abortion mandate for state group only (85)

HI - Prepaid Health Care Plans (74)

ID - Complications of Pregnancy (76)

IL - Raped or Sexual Assault (75,82); Psychologists Mandated Through Regulation (76); Liver Transplants (84); All persons licensed under medical practice act are entitled to reimbursement if legally able to provide contract benefit (82)

KY - Newborn Nursery Care (80); Nursing Home (86)

LA - Non-group to age 65 (74)

MD - Partial Psychiatric Hospitalization (76); Blood Products (75); All Providers (83); Orthopedic Braces (78); Invitro Fertilization (85); OP benefits resulting from UR programs (85)

MI - Non-group Medicare Complimentary Coverage (85); Mental Hospitals (83)

MS - Pre-existing Conditions (82)

MO - Pharmacists (78)

MT - Professional Counselors (85); Denturists (85)

NH - Pastoral Counselors (83)

NV - Chinese Medicine (75)

NJ - Diagnostic X-rays by Chiropractors (76)

NY - Pre-admission Testing (76); Ambulance Cancer Treatment (82); Nursing Home Option (X)

ND - Continued Coverage after HMO Selections (83)

NH - Practitioner Mandates of 1977 do not apply to Plan; Lay Midwives (85)

OH - OP Dialysis (72)

OR - Denturists (80)

SD - Reimburse all "Healing Arts" Practitioners (80); COB Prohibitied (81)

TN - School Psychologists (82)

TX - OP Psychiatric Centers (83)

VA - Opticians (77); Termination Notice (82); Mandated Benefit Option (82)

WI - Tuberculosis; Skilled Nursing Homes (75); COB (80); Kidney Disease (74) Insulin Infusion Pumps (81)

WY - Licensed Practitioners (71)

Chairman STARK. Thank you.

Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman.

I would like to ask Mr. Patricelli's comments on the conclusion of the first statement which we had today by Mr. Crandall of American Airlines. In summary, he said, legislation prescribing mandatory or employer-paid health benefits for employees and retirees will accomplish four important objectives.

First, it will serve to keep responsibility for health care in the private sector where it can be administered on the most cost effective basis.

Second, it will provide a more equitable distribution of health costs.

Third, it will eliminate the practice of reducing benefits for competitive reasons.

And, fourth, it ultimately will lower total health care costs as more employers attach importance to maintaining the good health of their employees.

Obviously, you have a contrary view, and I refer you back to this in order to try to draw you out and see if we can highlight why you disagree.

Mr. PATRICELLI. Mr. Gradison, I won't attempt, unless you wish, to comment on each of those four points, but rather more broadly on Mr. Crandall's view.

It seemed to me—and I will do that in two respects. First, it seemed to me that much of his testimony was based upon a desire by large employers in particular to see more of a level playing field and a lack of cost shifting by what they perceive as a result of lack of coverage by small employers, and we have within the chamber health care council points of view in that direction as well.

I would say that the record is not clear on who is shifting to whom. Clearly the larger part, I believe, of cost shifting to employers of all sizes comes from Government, not from internal inconsistencies in private coverage; and the cost shifting that comes from the Medicare and Medicaid programs and the changing policies in that regard has probably exceeded the cost shifting associated with lack of coverage in the private sector.

Second, larger employers are now getting the advantage of a variety of cost containment techniques, particularly associated with price bargaining with providers, hospitals and physicians, through preferred provider organizations that are giving them discounts that small employers by and large are not getting. And we see a substantial amount there for provider cost shifting back to those who have less intrusive, shall I say, cost containment provisions, particularly small employers. So which way the net cost shifting may play within the private sector is quite unclear to me.

The second point I would say about this general point of view on mandating coverage for those employers who don't now offer it, while there is an element of the business community which is considering this, typically they do so with some very strong caveats that I would mention. And while this is not a U.S. Chamber point of view, let me nevertheless state what some of those caveats are.

First, by and large, they don't trust the Congress in keeping the minimum benefit level reasonably low. There has been, after all, a

history of incremental additions to these kinds of things, and even for large companies there is some real concern about that if Congress got into this kind of policy.

Second, they feel that any such a proposal has to be considered in the light of preempting State benefit mandates. We can't have both Federal and State systems, and we urge you to confront that issue.

Third, all too often Congress has seen fit to exempt itself and Federal employees from these kinds of mandates and other governmental employees, and that needs to be terminated.

And, fourth, there is a very large problem associated with the Medicaid program and no effort at mandates in the private sector should be undertaken without at least consideration of what the Government's responsibility is to that population.

Mr. GRADISON. Well, I have been struck in private meetings that I have held with people from major corporations—major in the sense of large employers with operations in many States—how they really want to have the flexibility to have a uniform national plan. Obviously, I think it is obvious they would prefer to do that on their own without having Washington tell them how to do it, but they don't want the States to tell them how to do it either, because they don't want to have 50 separate plans covering a particular employee group.

I was surprised by their response. I don't know how general this view is, but the most interesting thing that I have heard recently in this field is from employers who say that they thought the Kennedy bill made a lot of sense because they believe that through cost shifting they are paying not only the cost of their own employees, employee's families and retirees, but for some portion of the rest of the community through a combination of taxes and cost shifting.

They may be wrong about that, but I sense that perception and that is why I asked you the question about Mr. Crandall's testimony. I am just surprised that there is a consensus view within the U.S. Chamber of Commerce since my conversations with employers directly suggest that there is the kind of difference of opinion within the business community that the hearing today suggests, with Mr. Crandall representing a viewpoint which isn't just held by American Airlines, and you are representing a point of view which I am primarily hearing from smaller employers.

I am not trying to overdraw this. I am really trying to understand it because when you say, you know, why do all this just to bring in the 9 percent of people who would not be affected by my bill—it is my view that we should be sending a signal to those who are concerned about health care finance that we want to move away from first dollar coverage and that our national strategy is not to have national health insurance, which is generally thought of as a first dollar strategy, and that we would like to have coverage of a catastrophic nature for all groups in the population leaving a corridor for insurance to provide protection or for private savings up to that point where the catastrophic coverage begins.

The way I look at it is that we can begin with the elderly, elderly acute, add the employed nonelderly and possibly some assistance to voluntary risk pools, leaving that up to the States by providing ERISA waivers if the States wish to move ahead, and then perhaps

over the next year or two, try to think through the possibility of some kind of a Medicaid buy-in, perhaps on a sliding scale related to income, for most of the people that are left. The buy-in might theoretically be a combination of Government funds, private funds and employer funds, if there were an employer in the picture.

In other words, I am trying to think through a strategy that will in time, without a uniform national Government-paid plan, provide catastrophic protection for the whole population. And so what looks like 9 percent seems to me to be a sound way to go.

It is true that we are getting into the area of the States, but that is nothing new. We got into regulating employer-provided health benefits from the moment we passed a nondiscrimination provision. That is a very clear cut standard. We have changed it over the years, but we have had nondiscrimination standards for a long time. The continuation benefits, which we put in a few years ago, are an additional step in this direction.

It may be a wise or unwise policy, but I think it is difficult to argue that we haven't taken the first step—first couple of steps actually—in that direction.

I think that perhaps a third example, which may be slightly different, would be the requirement that for the working aged Medicare become secondary payor, which in effect requires private employers to pick up that share of the cost for their elderly workers.

You have explained your points well. I really am not trying to comment at the length that I just did for argumentative purposes. I am trying to think this through. If you have further comments, I would welcome them, although I have to say I think you have covered the issues quite well already.

Mr. PATRICELLI. Well, I might just respond in two brief ways. First, the issue of simplifying the mandate picture is separate from whether the Federal Government ought to enact its own set of mandates. If this committee had a bill that wanted to preempt State mandates, as indeed ERISA does for self-insured plans, I think there would be large elements of the business community that would be very interested in that.

I guess our concern is that you shouldn't do both. You shouldn't start down both, or permit both tracks to be trod.

The second point is, I would note that in the prepared testimony, on page 7, we do propose an approach of preempting in a limited fashion State benefit mandates so that employers of all sizes could offer a kind of bare-bones catastrophic package, and I think that would significantly expand private insurance protection in a voluntary way right now where the overlapping mandates in many States is very difficult to get kind of bare-bones package out that small employers might find affordable.

Mr. GRADISON. This is the point covered on page 7 of your testimony. Very good. Thank you so much.

Mr. PATRICELLI. Thank you, sir.

Mr. GRADISON. And thank you, Mr. Chairman. I appreciate it.

Chairman STARK. Mr. Coyne?

Mr. COYNE. Nothing.

Chairman STARK. Mr. Moody?

Mr. MOODY. No questions.

Chairman STARK. Mr. Donnelly?

Mr. DONNELLY. Mr. Patricelli, I am sorry I missed your presentation. You are an expert in the field and you are chairman of the committee at the chamber that keeps an eye on health care policy.

I guess my question is this constant talk of expanding health care for the American people. Very little talk about cost containment. The enormous increases in the cost of hospitalization, physician fees, et cetera.

Does the chamber have, or do you have, any personal observations or opinions about how we ought to be dealing with this increasing cost of health care? I mean, it seems to me at the same time we talk about expansion, we ought to be talking about cost containment. That is in the Government interest, and it is in the private sector interest. You people are paying those premiums just like we are pumping the money out of the trust fund.

Can you enlighten the committee on some recommendations or does the chamber have a specific set of recommendations on cost containment?

Mr. PATRICELLI. We touch on it in part in our Medicare policy, but let me respond, I hope not to randomly, to your excellent point, Mr. Donnelly. I, personally, believe that we are spending too much for the health care that we are getting in this country, but that we may end up spending in actual dollars more in the future for better health care.

Now a great deal of the expenditures, as much as a quarter to a third of what is spent on health care by both the Government and the private sector is for procedures, both diagnostic and treatment procedures, that have no scientific basis.

Mr. DONNELLY. For example?

Mr. PATRICELLI. Oh, for many years there was a particular drug treatment of cataracts in the eye—of glaucoma in the eye that had never been field-tested through clinical trials in an appropriate fashion, and it was finally disproven after a decade of high expenditure. Or researchers at Duke have shown that PAP smears given once every year for most women are cost ineffective. That you get 99 percent of the benefit at a third of the cost if you do it every three years.

The point I am making is that there are tens, maybe a hundred billion dollars worth of spending that is going on for procedures which are not efficacious, and if we could get a handle on some of that there would be more than enough money in the system to do whatever people wanted to do.

This is, by the way, a problem that the Congress to my knowledge hasn't much gotten into or investigated. I, for one, on the other hand, am not particularly troubled by the rise in the amount of GNP that is going to health care spending. I don't know whether it ought to be 10.7 or 11.5 or 12 percent. The question is are we getting value for that? It may be that higher levels of health care spending produce benefits in terms of longevity and general well-being that perfectly justify that.

So within that broad parameter, what about cost containment? We have within the chamber said that it ought to be possible for the same cost containment techniques that are used in private coverage to be applicable to the Medicare program and to be administered on a consistent basis within the private sector so that a com-

pany can administer its retiree benefits and expect to have Medicare using the same kind of cost containment features. And I could go into detail on that, but that is a particular for you.

By and large, the private sector has led the Government in the application of cost containment features with the exception of the DRG system.

Mr. DONNELLY. Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody?

Mr. MOODY. Just briefly.

Mr. Patricelli, do you feel that the nontaxable treatment of health fringe benefits reduces incentives for cost containment? Let me reverse the question.

If employees had to pay some tax for in-kind income such as employer-paid fringe benefits for health, if they had to consider that at least in some part as taxable income, above some threshold, do you think employees and their representatives as well as employers might be more cost conscious than they are today?

Do you think there would be a cost containment side effect of that tax change if one were ever enacted?

Mr. PATRICELLI. I don't really, Mr. Moody. I, in years past, thought about that a lot and I think it is a proposal that can perfectly well be considered from a revenue-raising point of view, but I found its cost containment impacts to be negligible. Most private insurance coverage is now not first dollar coverage. That is a change from just 10 years ago, and it is moving away from first dollar coverage with the imposition of deductibles and copayments. And those point of service charges are what can have some cost containment effect. But a once a year deal with the Federal Government around your tax return doesn't seem to me to motivate people to constrain unnecessary medical utilization.

Moreover, Mr. Moody, I have found it difficult in my own mind to imagine why the Congress would want to tax one kind of employee benefit and not another, especially when the employee-benefit world is moving toward what is called flexible benefits or cafeteria plans where employers are saying we will put so much money on the table, you decide within certain limits how you want to spend it. Having a tax policy associated with one slice of that pie is inconsistent with what is happening out there in the real world.

Mr. MOODY. I wasn't actually asking whether or not we should only tax health. I am just saying insofar as we tax health and maybe other benefits as well, are employees going to say, wait a minute, I have got to pay a certain fraction of this now because of the new tax treatment, and I want to make sure I am getting the best possible buy for my buck? You don't see that as an influence, do you?

Mr. PATRICELLI. I really don't. I think any employee doesn't have to be an economist to know that he is better off having the employer paying his health insurance premiums even if some portion of that premium is taxable to him at a 28 or 30 percent—38 percent rate. He is better off, isn't he?

Mr. MOODY. Of course. That is not the issue. I am saying, if we have made that threshold decision as we almost did or started to make in the 1986 tax package, that there will be some fraction of some threshold that is taxable. If that were behind us, do you think

after that point the employee would say not, "Yes, I was better off before." Of course he was. But I am saying, having that behind us, would the employee or his representative say, "Hey, let us not look for the Cadillac version here, let us look for the Ford or the Valiant or the Plymouth version here, because this is now costing us something every April 15." The more expensive it goes, then their fraction which is taxable goes up, so it seems to me that the commentary in this field has been that this will make employers more sensitive. So it is an empirical question. But you say you don't think so?

Mr. PATRICELLI. Well, let us take a hypothetical. If an employee were receiving $3,000 worth of health care coverage and the ceiling for tax-free treatment was $2,500, wouldn't he still want to have the employer pay for that extra $500, even though it was taxable to him, because that is better off than him paying for it out of pocket?

Mr. MOODY. Well, of course. That is not what I am asking you. I am not asking you anything about that.

Mr. PATRICELLI. Oh, I am sorry.

Mr. MOODY. Of course he would like to have the employer pay anything. But suppose he had to pay tax now on $500 as opposed to not paying taxes on $500. If the law were changed to make him pay some tax on that $500, would he put more pressure on his representatives or on the employers to shop for a more economical plan, do more cost comparisons, to look for less of a Cadillac version in the health care package of the plan they selected?

Mr. PATRICELLI. I don't think it would, Mr. Moody, but I would argue that that is not the approach to cost containment that has been used and would likely work in the private sector. I think what is being done by way of preferred provider arrangements and precertification techniques and discount purchasing and all these other things that are going on in the competitive sector have—and prospective payment that you have initiated at this committee level—those are better approaches than trying to come up with some number that is the right number for health care coverage.

Mr. MOODY. I guess I am just not making myself clear. Those are wonderful. It is not either/or. But I think we all would agree the general proposition is if something costs you something you are more careful about the price level that is being spent.

Mr. PATRICELLI. Well, why wouldn't you take that approach to group life insurance, disability insurance, pension benefits and everything else? Why say that a certain amount of health insurance is too much but not a certain amount of pension coverage?

Mr. MOODY. I am not saying any of that. I am not saying anything is too much. I am only asking you, if the employee feels some of the price of the package in any field, for any benefit you might name, if he feels some of the price through the Tax Code as well as anything else, is he going to be more—is he going to ask for a more efficacious, cost effective program? That is all I am asking.

And you are saying no. It sort of defies the business rules of principle and the whole supply side concept that incentives matter, prices matter, people make judgments to contain costs if they feel the cost, and if they don't feel the cost, they don't.

I am asking you, if they feel the cost in one more way, I am suggesting, would this make a difference? You are saying no. If that is what you are saying; fine.

Mr. PATRICELLI. I am having trouble even understanding how it could make a difference. Even if the employee were taxed on that $500 I was talking about, he is getting, let's say, 70 percent of the benefit of it. Why wouldn't he rather have that?

Mr. MOODY. Of course he would rather have that than nothing. The question is, if he is taxed on $500 and the next year it goes to $800 and then $1,200 because of lack of cost containment inside the program, is he going to say, "Hey, wait a minute; my tax is going up because we don't have a very effective cost containment effort?" We are not price shopping hard enough here. My tax has gone up now; I had a $500 addition to my AGI last year, now it is $800, and this year I see it is going to go to $1,200. Is that going to raise his interest in keeping health costs down? That is my question. Not whether or not he would be better being untaxed. Of course he would be better off being untaxed. That is not my question.

Mr. PATRICELLI. Well, I won't pursue it, but it doesn't strike me as a logical conclusion by the employee, nor do I think the system would be particularly administrable by you because there would be great difficulty in knowing what an appropriate cap level ought to be and what are the forces for inflation and are they good or bad.

Mr. MOODY. I give up. Thanks.

Mr. PATRICELLI. I am sorry I can't agree with you, sir.

Chairman STARK. Mr. Patricelli, did the U.S. Chamber support the State risk pools proposal we introduced last year?

Mr. PATRICELLI. It did not in 1986, Mr. Chairman, but there is some language that has been very recently adopted by the U.S. Chamber board within the last month that represents new policy in that regard, and I would be happy to submit that for the record and read it to you. It is two sentences. If you would like.

Chairman STARK. What you are suggesting is that they now support it?

Mr. PATRICELLI. They are supportive of narrowly targeted risk pools at the State level which are constrained to the medically uninsurable and the subsidies for which, to the extent necessary, are spread over the broadest possible base including general revenues.

Chairman STARK. They come kicking and screaming into the 20th century, don't they?

Did the chamber support the Gramm-Rudman proposals?

Mr. PATRICELLI. Yes, we did.

Chairman STARK. And you are now complaining about the process under which we legislate?

Mr. PATRICELLI. Yes, Mr. Chairman. I think there are certain major policy issues that should be dealt with through full debate rather than through rider to "must" bills, even though I recognize that from the point of view of getting them through there is a sore temptation to have them.

Chairman STARK. How does that wash with Gramm-Rudman and sequestering?

Mr. PATRICELLI. Well, I am not enough of a legislative expert to know where the inconsistency may be.

Mr. MOODY. Will the chairman yield?

Chairman STARK. Be glad to.

Mr. MOODY. Does the chamber support a balanced budget amendment to the Constitution?

Mr. PATRICELLI. I will have to defer to Mr. Klein.

Mr. KLEIN. Yes, sir.

Mr. MOODY. Do you agree with the commentary that many observers have offered that if we do that, you will see a proliferation of mandated benefits pushed off onto the private sector? That a balanced budget at the Federal level will encourage a lot of legislation to force the private sector to do things the Government can't afford to do under a balanced budget amendment?

Mr. PATRICELLI. That could happen, Mr. Moody, but it need not happen. One would hope that the Government could manage its budget in such a way as not to have to transfer costs to the private sector.

Mr. MOODY. One could hope, but I think you would agree that there has been a lot of objective commentary that this was what, in fact, will probably result. Political pressures being what they are to cover people here and cover people there, it will be very tempting to mandate benefits if we have a balanced budget amendment.

Chairman STARK. Thank you very much, gentlemen.

[Whereupon, at 11:44 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF W. RANDALL RAWSON
DIRECTOR OF GOVERNMENTAL RELATIONS
AMERICAN CHIROPRACTIC ASSOCIATION

SUBCOMMITTEE ON HEALTH, HOUSE WAYS & MEANS COMMITTEE

ON

INSURANCE PROTECTION FOR INDIVIDUALS UNDER AGE 65

My name is W. Randall Rawson. As its Director of Governmental Relations, I submit this statement on behalf of the American Chiropractic Association, which represents over 16,000 practicing doctors of chiropractic nationwide.

Mr. Chairman, the American Chiropractic Association strongly supports the concept of mandated health insurance and efforts to enact legislation expanding access to health insurance to millions of additional Americans. In so doing, however, we want to call to your attention an existing problem regarding the manner in which ERISA impacts the rights of the health-care consumer, in the hope of avoiding the inadvertant creation of a similar problem by whatever final legislation might come from these hearings.

The issue pertains to a beneficiary's freedom to choose the health-care provider of his or her choice; the problem is the federal preemption of state laws which guarantee this freedom.

We know, Mr. Chairman, that you are personally familiar with this issue and we deeply appreciate the fact that you were the prime sponsor of legislation in the House during the 99th Congress proposing to resolve the impact of ERISA's preemption of state insurance equality laws. Although the issue as it specifically pertains to ERISA is not yet resolved, it is important, we are sure you agree, to avoid legislating identical preemptive measures in future legislation and equaly as important that mandated health insurance bills contain a position statement as to health consumer freedom of choice.

For the information of the subcommittee, so-called insurance equality laws have been enacted in 44 states (a list is attached for your ready reference). These state statutes guarantee a health care consumer's right to select a licensed practitioner of her or his choice to render needed health-care under policies of insurance sold within those states. In some instances, these statutes actually mandate certain benefits which must be offered by insurance companies doing business in the state.

Insurance equality laws protect the health-care consumer's right to choose. They "level the playing field", if you will, by assuring that the consumer has access, under health benefit plans, to the widest array of qualified, licensed health-care providers for the treatment of health conditions, without consideration as to which provider's services are or are not reimbursed under any given plan. Aside from the protection of patient's rights, such state statutes are an important component in insuring competition in the health-care delivery system. In medically underserved areas they assure a consumer's access to quality care, where otherwise it might not be available.

It is vital that any legislation which seeks to expand health insurance coverage to those presently without coverage recognizes the importance of state insurance equality laws and maintains such state regulation of all health bene-

fit plans -- including self-insured plans. This can be accomplished by the inclusion of legislative language similar to the following:

> "No provision of this Act shall be construed as limiting or preempting a provision of state law which requires that any health benefit plan must grant to a beneficiary the right to receive any health benefits from the health provider of his or her choice."

An alternative approach would be the inclusion of language providing federal guarantees of freedom of choice, similar to those provided by state law, as follows:

> "Any health benefit plan described by this Act shall not deny reimbursement for the care of any health condition covered under such a plan which is provided by a health care practitioner who is licensed by the state in which the care is performed and who is acting within the scope of that license."

The point is that the several states have taken action to assure patient freedom of choice of health-care provider. Although such state laws are consistent with the time-honored rights of the states to regulate insurance, attempts to insure patient freedom of choice through state law have been frustrated by legislative fiat in the past, most specifically through the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA includes a clause (Section 514) that allows States to continue to exercise regulatory authority over the "business of insurance", but preempts states from classifying employee health benefit plans as insurance. This clause has been interpreted in such a way as to allow self-insured health plans to be exempted from state laws pertaining to freedom of choice of health-care provider, mandated benefits, state premium taxes and reserve requirements for unpaid and unreported claims.

Therefore, in any quest for national uniformity, federal mandated health insurance legislation must guard against an ERISA-type preemption of state law. Otherwise, affirmative goals such as freedom of choice of health-care provider will be significantly compromised, with the primary victim being the very beneficiary for whom we are all trying to provide minimum levels of care.

The preservation of this patient right does not require mandating any specific new benefits or services, or mandating that any particular health-care practitioner be the sole provider of any specific service. Quite the contrary, a small legislative step like that which we recommend, opens up the health-care delivery system, injects competition, and makes the consumer's well-being the arbiter of health-care decisions.

Although well-intentioned, too many times federal health-care programs limit the provision of services to select classes of practitioners. Please remember that the generic term "physician" or "doctor" is not always automatically inclusive of all practitioners capable of performing covered services -- it may, in fact, statutorily limit whom a patient may see and from whom a patient may receive reimbursable services.

The states have recognized this fact, and, although the ERISA preemption problem still exists, we would hate to see expanded-access legislation exacerbate the problem by further limiting the extent to which state law may prevail.

STATE INSURANCE EQUALITY LAWS (Revised May 22, 1986)

* Alabama	* Maine	North Dakota **
* Arkansas	* Maryland	Ohio
* Arizona	* Massachusetts	* Oklahoma
California	* Michigan	* Pennsylvania
Colorado	* Minnesota	Rhode Island
* Connecticut	* Mississippi	South Carolina **
Delaware	* Missouri	South Dakota
+ Florida	Montana	* Tennessee
* Georgia	Nebraska	Texas
* Illinois	Nevada	Utah
* Indiana ++	New Hampshire	Virginia ++
* Iowa +++	* New Jersey	Washington
* Kansas	* New Mexico	* West Virginia
* Kentucky +++	* New York	* Wyoming
Louisiana	North Carolina	

* Language of statute includes insurance policies and health care contracts

** Rider only required

+ Includes self-insurers ++ Includes PPOs +++ Includes HMOs

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

May 15, 1987

The Honorable Fortney H. Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

RE: Catastrophic Health Coverage for Individuals Under Age 65 - May 12, 1987 Hearing of the Health Subcommittee of the Ways and Means Committee

Dear Chairman Stark:

The American Medical Association takes this opportunity to submit comments concerning the important issue of catastrophic coverage for the health needs of individuals under age 65. We request that this letter be included in the record of the May 12, 1987 hearing held by the Subcommittee on Health. A copy of our recommendations for catastrophic health insurance coverage is included with this letter, and we request that it also be included in the hearing record.

In recent months, considerable attention has been focused on catastrophic coverage for the health care needs of the elderly. While this attention is appropriate, the catastrophic coverage needs of the under age 65 population should not be ignored. People in this age group also experience chronic and acute health problems that could result in catastrophic losses without adequate health insurance protection.

For many years, the AMA has advocated that catastrophic health care coverage should be included as part of a package of minimum benefits in all health insurance plans. Such catastrophic coverage can often be provided at relatively small additional cost. In addition, even though the vast majority of persons would never actually use the catastrophic benefit, its mere existence would provide vital piece of mind.

In discussing catastrophic coverage, it is important to keep in mind that what constitutes a catastrophic expense varies from person to person -- based on individual financial resources. An expense that clearly would be catastrophic to a person with a minimum wage job might be easily manageable for an individual with a more substantial income.

The AMA believes strongly that adequate health insurance, including catastrophic coverage, should be furnished through the employment setting. Such coverage can and should be encouraged by limiting the tax deductibility of employer health plan benefit costs only to those employers who furnish health plans that provide such coverage and who participate in a statewide risk pooling program. Participation in risk pools should be seen as a vital element in assuring catastrophic health care coverage for the under age 65 population. Risk pools have the potential to make basic health insurance, including catastrophic coverage, available at a reasonable cost for persons who are uninsured, underinsured or uninsurable.

While risk pools have been established in twelve states, the current exclusion under the Employee Retirement Income Security Act (ERISA) of self-insured plans from state regulation has created an insurmountable impediment to the establishment of effective state risk pools. We strongly urge appropriate amendments to ERISA that would allow states to regulate self-insured health plans for the purpose of requiring them to comply with state laws, including those requiring risk pools.

Workers who are laid off should have the opportunity to maintain employment-based health insurance for at least several months after their termination if they continue to pay the same portion of the insurance premium they paid while employed. In addition, we support the recently enacted legislation, P.L. 99-272, that requires employers to make group rate coverage available for terminated workers at the worker's sole expense for an additional 18 months.

Catastrophic coverage for low-income persons who lack employment-based coverage and who do not qualify for Medicaid should be provided through vouchers for the purchase of private health insurance.

We will be pleased to work with you on this important issue of mutual concern.

Sincerely,

James H. Sammons, M.D.

JHS/jmj
3050p

Catastrophic Health Insurance Coverage: AMA Recommendations

I. Medicare Elderly

The following recommendations concerning Medicare are intended to be short-term pending long-term structural modifications of the Medicare program necessary in order to stave off its otherwise inevitable fiscal bankruptcy.

A. Acute Care - Private Sector

- Catastrophic coverage preferably should be provided through private insurance rather than under a government program.
- The Baucus Amendment (Section 1882 of the Social Security Act), which specifies requirements for Medicare supplemental coverage, should be materially strengthened to assure meaningful coverage:
  - -- insurers should offer full coverage policies that include a stop-loss provision limiting the insured's liability to a specified amount, and offer a "catastrophic only" coverage option.
- Vouchers or tax credits should be used to help the 15% to 20% of the elderly who have neither Medigap nor Medicaid coverage to pay the premiums for private Medigap policies that include catastrophic protection.

B. Acute Care - Public Sector

In the event that the private insurance industry does not respond to offer satisfactory catastrophic coverage, then an expansion of Medicare should be considered with the following principles:

- All Medicare beneficiaries should participate in catastrophic coverage;
- Coverage should be limited to acute care costs and benefits provided should be funded through new revenues; and
- The program should provide means-testing through a combination of a means-related additional premium for all beneficiaries, copayments scaling the out-of-pocket expense limit to a beneficiary's income and resources, and a tax on a portion of the actuarial value of Medicare benefits.

C. Long-Term Care (Private Sector Coverage)

- Personal savings to pay the cost of long-term care should be encouraged in the following ways:

(1) by permitting tax deductible contributions to an Individual Medical Account; and

(2) by allowing tax-free withdrawal of Individual Retirement Account funds for any long-term care expense.

- In order to stimulate the private market for long-term care insurance, a refundable tax credit should be allowed for long-term care insurance premiums.

- Barriers to prefunding long-term care benefits provided by employers to retirees should be removed.

II. Working Population

Adequate health insurance providing specified minimum benefits, including catastrophic coverage, should be furnished in the employment setting. Such coverage should be encouraged by limiting the tax deductibility of employer health insurance premiums only to employers

-- who furnish health plans that provide the specified adequate benefits and catastrophic coverage, and

-- who also participate in a statewide risk pooling program.

The development of a statewide risk pooling program is essential to make coverage available to high-risk individuals, uninsured and underinsured individuals and small employers. All insurers, including the self-insured, should be required to participate in such pools. Necessary amendments to ERISA should be made in order for the State to create effective pools.

III. Medicaid and Near Poor

State Medicaid programs should provide uniform benefits to afford comprehensive protection including catastrophic coverage, with full "wrap around" coverage for the Medicare eligibles. Access to a wide range of provider and physicians should be assured through equitable reimbursement levels.

Catastrophic coverage for low-income persons without employment-based coverage and who do not qualify for Medicaid should be provided either through vouchers for private insurance or a Medicaid program expanded to cover those in need.

2257s

ERIC

THE
ERISA
INDUSTRY
COMMITTEE

STATEMENT OF

THE ERISA INDUSTRY COMMITTEE

ON

H.R. 2300

A BILL TO REQUIRE HEALTH PLANS OFFERED BY EMPLOYERS
TO HAVE CATASTROPHIC COVERAGE

SUBMITTED TO THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

MAY 12, 1987

HEARING ON

CATASTROPHIC HEALTH EXPENSES FOR INDIVIDUALS UNDER AGE 65

THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS WILL SOON BE ASKED TO CONSIDER ENACTMENT OF A BILL, H.R. 2300, WHICH WOULD MANDATE THAT EMPLOYERS WHO PROVIDE HEALTH COVERAGE TO THEIR EMPLOYEES INCLUDE IN THEIR HEALTH PLANS SPECIFIC OUT-OF-POCKET LIMITS OF $2000 FOR AN INDIVIDUAL AND $3500 FOR A FAMILY. THE BILL WOULD NOT APPLY TO EMPLOYERS OF FEWER THAN 20 EMPLOYEES; NOR WOULD IT APPLY TO EMPLOYERS WHO DO NOT PROVIDE HEALTH COVERAGE FOR THEIR WORKERS.

THE ERISA INDUSTRY COMMITTEE (ERIC) IS AN ASSOCIATION OF MORE THAN 100 OF THE NATION'S LARGEST EMPLOYERS CONCERNED WITH NATIONAL RETIREMENT AND EMPLOYEE BENEFIT ISSUES. ERIC MEMBER COMPANIES SPONSOR PENSION, SAVINGS, HEALTH AND OTHER BENEFIT PLANS COVERING OVER EIGHT MILLION WORKERS AND THEIR FAMILIES.

WE BELIEVE H.R. 2300 WILL HAVE MAJOR AND SURPRISINGLY ADVERSE CONSEQUENCES ON HEALTH CARE DELIVERY THROUGH EMPLOYER-SPONSORED PLANS. IMPOSING SPECIFIC PLAN DESIGNS ON THOUSANDS OF DIVERSE EMPLOYER-SPONSORED HEALTH PLANS IS AN ENTIRELY DIFFERENT MATTER FROM SETTING SPECIFIC LIMITS WITHIN THE MEDICARE PROGRAM. AS ILLUSTRATED BELOW, MANY EMPLOYERS MAY BE FORCED TO CHANGE THE DESIGN OF THEIR HEALTH BENEFITS IN WAYS THAT IMPACT ADVERSELY ON BOTH THE PLAN BENEFICIARIES AND THE EMPLOYERS. THOSE CHANGES MAY FAR OUTWEIGH ANY CATASTROPHIC BENEFIT IMPROVEMENTS.

WE STRONGLY URGE THAT THE COMMITTEE NOT APPROVE H.R. 2300.

EMPLOYER-SPONSORED HEALTH PLANS COVER SOME 132 MILLION AMERICANS UNDER THE AGE OF 65. PLANS SPONSORED BY ERIC COMPANIES ALONE COVER APPROXIMATELY 20-25 MILLION INDIVIDUALS. WE SHARE THE CONCERN OF CONGRESS ABOUT INDIVIDUALS WHO DO NOT HAVE HEALTH COVERAGE OR WHOSE HEALTH COVERAGE IS INADEQUATE, AND WE HAVE A STRONG INTEREST IN SEEKING WORKABLE SOLUTIONS.

TO THAT END, ERIC STAFF AND ITS MEMBERS ARE CURRENTLY WORKING WITH CONGRESSIONAL STAFF TO DEVELOP COMPREHENSIVE MEANS OF MAKING AFFORDABLE HEALTH CARE COVERAGE AVAILABLE TO THOSE WHO ARE UNCOVERED. WE APPRECIATE THIS OPPORTUNITY TO WORK WITH THE SUBCOMMITTEE ON HEALTH.

WE HAVE CAREFULLY REVIEWED H.R. 2300 AND HAVE THE FOLLOWING OBJECTIONS:

1. H.R. 2300 FAILS TO ADDRESS THE PROBLEM OF THE 30 TO 37 MILLION AMERICANS WHO CURRENTLY ARE WITHOUT HEALTH CARE COVERAGE. INSTEAD IT IMPOSES SPECIFIC PLAN DESIGN REQUIREMENTS ONLY ON EMPLOYERS ALREADY PROVIDING HEALTH COVERAGE FOR THEIR EMPLOYEES.

THIS LEGISLATION SETS A PRECEDENT OF SPORADIC FEDERAL INTERFERENCE WITH PLAN DESIGN. THERE IS ALREADY A PATCHWORK OF OVER 680 SEPARATE AND INCONSONANT MANDATED BENEFIT LAWS IN THE STATES, INCLUDING NUMEROUS CONTINUATION COVERAGE AND CATASTROPHIC COVERAGE REQUIREMENTS. OVER THE PAST DECADE, AS STATES ENACTED MORE MANDATED BENEFIT LAWS, AN INCREASING NUMBER OF EMPLOYERS RESPONDED BY CREATING SELF-FUNDED PLANS TO PROVIDE THE BENEFITS THEIR EMPLOYEES NEEDED. THESE PLANS ARE PREEMPTED FROM STATE MANDATES UNDER ERISA. INDEED, THE EXCESSIVE BURDENS IMPOSED BY MANDATED BENEFITS HAVE LED AT LEAST FIVE STATES (ARIZONA, NEBRASKA, OREGON, PENNSYLVANIA, AND WASHINGTON) TO ADOPT BENEFIT EVALUATION MECHANISMS TO ASSESS THE COST/BENEFIT TRADE-OFFS OF STATE MANDATED HEALTH BENEFITS BEFORE THEY CAN BE ENACTED.

INSTEAD OF INCREASING COVERAGE UNDER EMPLOYER HEALTH PLANS, PASSAGE OF H.R. 2300, AND THE DOOR IT OPENS TO OTHER MANDATED BENEFITS LEGISLATION, WILL CAUSE OVERALL HEALTH COVERAGE UNDER EMPLOYER PLANS TO DECREASE.

2. IT IS UNCLEAR HOW MANY INDIVIDUALS ACTUALLY WOULD BE TARGETED BY THE LEGISLATION: THE EXPLANATION ACCOMPANYING THE BILL (SEE CONGRESSIONAL RECORD, MAY 6, 1987, PAGES E 1775-6) CITES AN HHS STATISTIC THAT 7-10 MILLION AMERICANS WITH HEALTH COVERAGE ARE "UNDERINSURED". HOWEVER, ONLY A PORTION OF THESE WOULD BE AFFECTED BY THIS LEGISLATION SINCE EMPLOYERS WITH FEWER THAN 20 EMPLOYEES ARE EXEMPT FROM THE BILL.

NOR IS A SPECIFIC DEFINITION OF "UNDERINSURED" PROVIDED SO THAT CONGRESS AND EMPLOYERS CAN DETERMINE WHETHER A CATASTROPHIC LIMIT SUCH AS THAT ENVISIONED IN THIS BILL HAVE A MATERIAL EFFECT ON THESE INDIVIDUALS.

THE INCREASED PREMIUM COSTS TO EMPLOYEES IN SOME PLANS MAY CAUSE SOME WORKERS TO DROP THEIR CURRENT COVERAGE. ESTIMATES SHOULD BE PROVIDED OF THE NUMBERS OF EMPLOYEES EXPECTED TO DROP COVERAGE UNDER THEIR EMPLOYER PLAN.

IN SUMMARY, BETTER ESTIMATES SHOULD BE PROVIDED OF THE ACTUAL NUMBER OF INDIVIDUALS WHOSE COVERAGE WOULD BE MATERIALLY CHANGED BY THIS PROVISION.

3. SEC. 2(C) OF H.R. 2300 INCLUDES A PROVISION WHICH STATES THAT A GROUP HEALTH PLAN WILL MEET THE REQUIREMENTS OF THE BILL ONLY IF:

> "(B) THE PLAN DOES NOT CANCEL OR DIFFERENTIATE IN COVERAGE OF A COVERED INDIVIDUAL OR COVERED FAMILY MEMBER FOR ANY REASON RELATING TO THE HEALTH STATUS OR ACTIONS OF THE COVERED EMPLOYEE OR MEMBER, OTHER THAN FAILURE TO PAY THE PREMIUM."

THIS PARAGRAPH APPEARS TO HAVE SEVERAL FAR-REACHING CONSEQUENCES WHICH EXCEED THE STATED LIMITED PURPOSE OF THE LEGISLATION:

A. SUBPARAGRAPH (B) APPEARS TO PRECLUDE PLANS FROM NOT COVERING PRE-EXISTING CONDITIONS. THIS WOULD BE A DRAMATIC AND POTENTIALLY EXPENSIVE CHANGE IN PLANS WHICH CURRENTLY HAVE

PRE-EXISTING CONDITION LIMITATIONS, AND WOULD BE A MAJOR ADDITIONAL PLAN REQUIREMENT BEYOND THE OUT-OF-POCKET LIMITS WHICH ARE THE FOCAL POINT OF THE LEGISLATION.

B. SUBPARAGRAPH (B) APPEARS TO PRECLUDE PLANS FROM ESTABLISHING DIFFERING LEVELS OF COPAYMENT OR DEDUCTIBLES FOR DIFFERENT HEALTH PROBLEMS. FOR EXAMPLE, MANY PLANS IMPOSE LIMITS OR GREATER CO-PAYMENTS ON MENTAL HEALTH OR SUBSTANCE ABUSE CONDITIONS. MANY PLANS WOULD THEREBY HAVE TO REDUCE OVERALL COVERAGES TO COUNTERBALANCE THE REQUIREMENTS OF THIS BILL.

C. SUBPARAGRAPH (B) ALSO APPEARS TO PRECLUDE PLANS FROM ESTABLISHING DIFFERING LEVELS OF COPAYMENT OR DEDUCTIBLES IF AN EMPLOYEE DOES NOT FOLLOW COST CONTAINMENT OR MANAGED CARE PROCEDURES IN THE PLAN. FOR EXAMPLE, MANY PLANS IMPOSE PENALTIES IN THE FORM OF HIGHER DEDUCTIBLES OR COPAYMENTS IF THE COVERED INDIVIDUAL FAILS TO SECURE A SECOND OPINION FOR CERTAIN SURGICAL PROCEDURES, FAILS TO SECURE PRE- OR POST-ADMISSION CERTIFICATION FOR HOSPITALIZATION, FAILS TO RECEIVE TREATMENT AS AN OUTPATIENT INSTEAD OF AN IN PATIENT, OR FAILS TO USE THE PLAN'S PPO.

IN ADDITION, UNDER THIS PROVISION, THE PLAN MAY NOT BE ABLE TO PROVIDE FOR PAYMENT TO BE WITHHELD IF THE COVERED INDIVIDUAL WAS SUSPECTED OF SUBMITTING FRAUDULENT CLAIMS OR OTHERWISE VIOLATING PLAN PROCEDURES.

SUBPARAGRAPH (B) APPEARS TO HAVE A DEVASTATING IMPACT ON WIDE-SPREAD COST CONTAINMENT AND ANTI-FRAUD PLAN PROVISIONS.

D. SUBPARAGRAPH (B) WOULD REQUIRE PLANS TO DROP PROVISIONS THEY MAY HAVE WHICH EXCLUDE PAYMENT FOR INJURIES RELATED TO ATTEMPTED SUICIDES.

E. EVEN IF THIS PROVISION WERE AMENDED TO ALLOW USE OF COST CONTAINMENT PROVISIONS OR TO REQUIRE COVERED INDIVIDUALS TO FOLLOW ESTABLISHED PLAN PROCEDURES, THE EFFECT OF SUCH PENALTIES WOULD IN SOME INSTANCES BE VITIATED SINCE THEY WOULD STILL BE INCLUDED UNDER THE BILL'S OVERALL OUT-OF-POCKET LIMIT.

F. SUBPARAGRAPH (B) COULD BE INTERPRETED TO REQUIRE COVERAGE BEYOND TERMINATION OF EMPLOYMENT OR BEYOND CONTINUATION COVERAGE PROVIDED UNDER P.L. 99-272 (COBRA).

4. **MANY EXISTING HEALTH PLANS INCLUDE <u>PARTIAL</u> COVERAGE OF NON-CORE AND EXPENSIVE SERVICES** SUCH AS SUBSTANCE ABUSE TREATMENT, MENTAL HEALTH SERVICES, LONG TERM CARE, VISION CARE, DENTAL CARE AND ORTHODONTIC SERVICES. FOR EXAMPLE, THE PLAN MAY COVER A CERTAIN NUMBER OF DAYS OF TREATMENT OR PROVIDE A DOLLAR CAP ON AVAILABLE COVERAGE. GENERALLY THESE SERVICES ARE NOT INCLUDED IN OUT-OF-POCKET LIMITS PROVIDED IN THE PLAN.

IT IS UNCLEAR FROM THE BILL'S LANGUAGE HOW SUCH BENEFITS WOULD BE TREATED UNDER H.R. 2300. IF THEY ARE INCLUDED UNDER THE CATASTROPHIC LIMITS IN THE BILL, FOR MANY EMPLOYERS THE ONLY AFFORDABLE ROUTE WILL BE TO DROP THE COVERAGES FOR SUCH ITEMS ENTIRELY. THIS WILL, AGAIN, REDUCE, NOT INCREASE, IMPORTANT HEALTH BENEFITS FOR MILLIONS OF WORKERS AND DEPENDENTS.

IN OTHER INSTANCES, TO COVER THE INCREASED COSTS, AN EMPLOYER MAY INCREASE OUT-OF-POCKET LIMITS TO THOSE IN THE BILL, THEREBY REDUCING THE IMPORTANT PROTECTION AGAINST BASIC HOSPITAL AND DOCTOR EXPENSES THAT THE PLAN HAD PREVIOUSLY PROVIDED.

5. **H.R. 2300 MAKES NO PROVISION FOR THE INCREASINGLY POPULAR USE OF SALARY-RELATED OUT-OF-POCKET LIMITS.** UNDER THESE PLANS, DIFFERENT OUT-OF-POCKET LIMITS ARE PROVIDED IN DIFFERENT SALARY BRACKETS, OR AN OUT-OF-POCKET LIMIT IS SET AS A CERTAIN

PERCENTAGE OF PAY. REDUCING OUT-OF-POCKET LIMITS FOR THE HIGHEST PAID EMPLOYEES TO THE ARBITRARY LIMIT SET IN THE BILL MAY CAUSE LIMITS FOR THE LOWER PAID EMPLOYEES TO GO UP, A RESULT NEITHER POLICY MAKERS NOR EMPLOYERS WOULD WELCOME.

6. **THE BILL VITIATES THE PROVISIONS IN MANY PLANS FOR LIFETIME MAXIMUM LIMITS** OF, FOR EXAMPLE, $500,000 OR $1,000,000. ELIMINATING LIFETIME MAXIMUMS WILL INCREASE THE COST OF COVERAGE AND WILL BROADEN THE IMPACT OF THE BILL BEYOND THE LIMITED SCOPE DESCRIBED BY THE BILL'S SPONSORS. IT WILL EXPOSE PLAN SPONSORS TO OPEN-ENDED LIABILITIES WHICH WILL DISCOURAGE THE PROVISION OF HEALTH COVERAGE THROUGH EMPLOYER PLANS.

7. UNDER NEW SUBSECTION (N)(2), EMPLOYER PLANS WOULD BE RESPONSIBLE FOR PAYMENT OF

> "100% OF OTHERWISE ALLOWABLE COST OR CHARGE (WITHOUT ANY COINSURANCE, COPAYMENT, OR DEDUCTIBLE) FOR PHYSICIAN AND INPATIENT AND OUTPATIENT HOSPITAL SERVICES PROVIDED DURING A CATASTROPHIC BENEFIT PERIOD."

"OTHERWISE ALLOWABLE COST OR CHARGE" IS NOT DEFINED IN THE BILL. IT IS UNCLEAR BY WHOM SUCH ALLOWABLE COST IS TO BE DETERMINED. THIS COULD HAVE DRAMATIC CONSEQUENCES FOR CONCEPTS SUCH AS REASONABLE AND CUSTOMARY FEES, PAYMENT CONTRACTS, AND FOR GENERAL EXPENSES CHARGED BY PROVIDERS TO THE PLAN.

IN ADDITION, AS THE BILL IS CURRENTLY DRAFTED, SUBSECTION (N)(4), WHICH LIMITS THE DEFINITION OF OUT-OF-POCKET EXPENSES, DOES NOT APPLY TO SUBSECTION (N)(2). **THUS, ONCE A CATASTROPHIC BENEFIT PERIOD IS IN EFFECT, THE PLAN SPONSOR APPEARS TO BE LIABLE FOR ALL ADDITIONAL EXPENSES WHICH THE EMPLOYEE INCURS, REGARDLESS OF WHETHER OR NOT THE SERVICES ARE COVERED UNDER THE PLAN. THIS APPEARS TO BE CONTRARY TO THE INTENT OF THE BILL'S SPONSORS.**

8. **THE BILL WOULD INCLUDE ALL VOLUNTARY AS WELL AS INVOLUNTARY TREATMENT UNDER THE OUT-OF-POCKET LIMITS.** THIS COULD ALLOW EMPLOYEES TO BUNCH VOLUNTARY MEDICAL EXPENSES FOR ORTHODONTICS, VISION CARE, ETC., TOGETHER TO ENSURE THAT THE LIMIT WILL BE EXCEEDED AND 100% OF ADDITIONAL EXPENSES ASSUMED BY THE PLAN. CONSEQUENTLY, EMPLOYERS WILL BE LESS LIKELY TO INCLUDE BENEFITS IN SUCH AREAS IN THE PLAN AT ALL.

9. SUBSECTION (N)(4) DEFINES OUT-OF-POCKET EXPENSES, IN PART, TO EXCLUDE

> "EXPENSES INCURRED FOR WHICH REIMBURSEMENT IS NOT MADE UNDER A HEALTH BENEFIT PLAN SOLELY BY REASON OF THE FACT THAT THE EMPLOYEE OR INDIVIDUAL INCURRED SUCH EXPENSES FOR SERVICES PROVIDED BY A PERSON OR FACILITY, AND UNDER SUCH CIRCUMSTANCES, SUCH THAT PAYMENT UNDER SUCH PLAN IS NOT AUTHORIZED."

THE MEANING OF THIS SECTION IS NOT CLEAR. IT MAY IMPOSE LIABILITY ON THE EMPLOYEE FOR EXPENSES INCURRED BECAUSE OF FAILURE TO PERFORM SPECIFIC ACTS (SUCH AS COMPLIANCE WITH MANDATORY SECOND OPINION PROVISIONS, USE OF A PPO, ETC.) WHICH WOULD HAVE RESULTED IN PAYMENT UNDER THE EMPLOYER'S PLAN. IF THAT IS THE INTENT, WHICH WE WOULD SUPPORT, IT SHOULD BE STATED.

10. SUBSECTION (N)(5) ENTITLED "CONSTRUCTION" IS OVERLY BROAD.

"ILLNESS" AND "INJURY" COULD INCLUDE ELECTIVE ITEMS.

"REASONABLE AND NECESSARY", IN THE ABSENCE OF FURTHER EXTENSIVE DEFINITION, WILL RESULT IN FREQUENT LITIGATION WITH PROVIDERS CLAIMING THEIR SERVICES WERE REASONABLE AND NECESSARY AND PROGRAMS/CARRIERS/ADMINISTRATORS DISAGREEING.

IN ADDITION, THIS SUBSECTION LIMITS PAYMENTS REQUIRED FROM A PLAN, BUT DOES NOT LIMIT OUT-OF-POCKET EXPENSES WHICH COUNT TOWARD THE ONSET OF A CATASTROPHIC BENEFIT PERIOD. **AN EMPLOYEE COULD INCUR EXPENSES UP TO THE OUT-OF-POCKET LIMITS IN THE BILL WHICH WERE NOT RELATED TO THE TREATMENT OF ILLNESS OR INJURY AND THEN CHARGE THE PLAN FOR ALL ADDITIONAL EXPENSES.**

11. FINALLY, THE DEFINITION OF "GROUP HEALTH PLAN" UNDER SUBSECTION (N)(6)(C) DOES NOT APPEAR TO INCLUDE THE CONCEPT OF AN HMO. IF AN EMPLOYER PAYS A PER CAPITA FEE TO AN HMO TO PROVIDE ALL MEDICAL SERVICES AND THE EMPLOYEE GOES OUTSIDE THE HMO TO OBTAIN SERVICES WHICH THE HMO REFUSES TO COVER, H.R. 2300 WOULD APPEAR TO MAKE THE EMPLOYER LIABLE FOR THESE CHARGES.

IN SUMMARY, WHILE WE SHARE WITH THE COMMITTEE A STRONG CONCERN THAT EMPLOYEES AND DEPENDENTS BE PROTECTED AGAINST CATASTROPHIC HEALTH EXPENSES, WE BELIEVE THAT PASSAGE OF H.R. 2300 WILL DO GREAT HARM TO THE EXTENSIVE COVERAGE ALREADY PROVIDED AND WILL EXERT A STRONG INFLUENCE ON MARGINAL EMPLOYERS NOT TO ENTER THE HEALTH CARE FIELD.

AS EXPERIENCE WITH THE COBRA PROVISIONS HAS SHOWN, PRIVATE HEALTH CARE IS A COMPLEX AREA, AND IT IS EXTREMELY DIFFICULT TO DRAFT EFFICIENT AND WORKABLE LEGISLATION THAT ACCOMPLISHES THE SPONSORS' PURPOSES. MOREOVER, WHEN THE SUBCOMMITTEE HELD A HEARING ON THIS GENERAL AREA, WRITTEN TESTIMONY PROVIDED BY THREE OF THE FOUR INVITED WITNESSES INCLUDED SPECIFIC ANALYSIS OF H.R. 2300 AS FOLLOWS: ONE STRONGLY RECOMMENDED AGAINST PASSAGE OF THE BILL; THE OTHER TWO EXPRESSED CONCERN THAT THE ADDITIONAL COST REQUIRED BY THE BILL WOULD CAUSE MORE DEPENDENTS TO LOSE COVERAGE THAN WOULD BE BENEFITED BY THE BILL.

WE STRONGLY URGE THAT THE COMMITTEE DISAPPROVE H.R. 2300.

WE WOULD BE PLEASED TO WORK AT ANY TIME WITH THE COMMITTEE ON THIS AND OTHER ASPECTS OF PROVIDING STRONG HEALTH CARE COVERAGE TO AMERICAN WORKERS AND THEIR FAMILIES AT ANY TIME.

6/5/87

CONGRESSMAN GEORGE MILLER
CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

TESTIMONY BEFORE THE
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS
Tuesday, May 12, 1987

Chairman Stark and Members of the Subcommittee, I appreciate this opportunity to testify regarding the catastrophic health needs of children.

I especially want to commend the Chairman for his leadership on these issues and for initiating a series of hearings to examine catastrophic insurance protection for individuals under age 65. Until recently, the discussion on catastrophic health insurance has largely ignored this group.

The President asked us to believe that his initiative would protect those most vulnerable to catastrophic illness.

But his proposal would protect only a fraction of the elderly, and none of the millions of young Americans who have a chronic illness or no health insurance.

Consider the stories of several parents, and their disabled youngsters, who recently testified before the Select Committee on Children, Youth, and Families:

The Reckeweg's five year old son from Clinton, Maryland was born with a severe breathing disorder resulting in a lengthy hospital stay. Their private insurance was exhausted in less than nine months because of a $100,000 cap on reimbursement. Now the family faces an $800,000 debt.

Twenty-five year old Joe became paralyzed after a bicycle accident in 1985. While his parent's employer-based insurance covered much of his initial medical care, recently his mother was forced to quit her job to care for him at home. As a result, her health insurance policy will soon lapse, leaving them with no way to pay the bills.

As these families demonstrate, debilitating illness or disability knows no discrimination on the basis of age.

MORE CHILDREN UNINSURED THAN EVER BEFORE

And today, the frightening reality is that more of us are unprotected than ever before. Children are especially vulnerable. Of the 35 million Americans without any health insurance, one-third - 11 million - are children. Millions more children have health care coverage that would leave them completely unprotected in the event of a catastrophic illness, even if their parents are fully employed.

Nearly 30% of today's uninsured children have employed parents with employer-sponsored health plans -- but the plans do not cover their children. This scenario is likely to worsen as new entrants into the workforce find that available jobs are in the traditionally low-wage, low-benefit service sector.

For the poorest children, public health insurance programs fail to provide adequate, if any, coverage. Millions of poor children are not covered at all, and millions more are not protected in the event of a catastrophic illness.

Fewer than half of all poor children, and only 60% of low-income disabled children, are covered by Medicaid. For low-income families, even the cost of routine medical care or care for a minor illness or surgery can be catastrophic.

INADEQUATE INSURANCE CAN IMPOVERISH A FAMILY AND INCREASE THE COST TO THE NATION

Few issues are of greater concern to this nation than ensuring family stability. Yet the stability of millions of American families is at risk when a child's illness or disability severely strains their finances, and in many cases, forces them into poverty.

More often than not, families with chronically ill or disabled children are denied health insurance when they need it most, face extraordinary out-of-pocket medical expenditures that wipe-out savings or result in family bankruptcy, or are forced to choose between poverty or their child's institutionalization.

Each of these situations not only undermines the fabric of family life, but generates enormous public costs. About 2 percent of the children in America use 20-30% of child health expenditures. A national survey of 85,000 admissions to children's hospitals revealed that only 1.3% had charges over $50,000, but they accounted for 26% of the total charges for all 85,000 admissions. In California alone, one half of one percent of all hospital admissions of children cost $280 million, or 22% of hospital costs for the state's children.

HOME CARE FOR CHRONICALLY ILL AND DISABLED CHILDREN IS LESS COSTLY THAN INSTITUTIONALIZATION, BUT INSURANCE STILL INADEQUATE OR NONEXISTENT

Most striking was the information we received about the cost-savings inherent in home-based care versus hospital-based care for these most vulnerable children. Many families, however, still struggle financially and emotionally when they choose home-based care.

For some children home care is still costly, but much less costly than hospitalization.

*In California, the cost of institutionalization for a child with cerebral palsy is $1,400 per month, twice the $700 monthly cost of home care.

*In Maryland, the cost of home care for ventilator dependent children is $9,000 per month, 36% of the cost of hospital care ($24,800 per month).

*Based on costs in other states, including Pennsylvania and Illinois, the cost of home care for technology-dependent children ranges from 16% to 23% of the cost of hospital care.

*A twenty state hospital survey, released by the American Association for Respiratory Therapy in 1984, found that the average cost of care for ventilator dependent persons was $270,830 per person per year in a hospital versus $21,192 per person per year at home. The estimated annual savings for children in this sample alone would be $64.4 million.

*In 1984, Utah's Primary Children's Medical Center reviewed patients, including infants in special care, ventilator-

dependent children, medical surgical patients and others, and found that third-party payors combined, including Medicaid, could save as much as $900,000 per year in hospital expenses if these children were cared for at home.

*In 1983, an Illinois study found that, over a four-year period, the State of Illinois saved more than $4 million treating ventilator-dependent children who returned home.

The Select Committee also heard directly from young adults, and families with chronically ill children, who choose home-based care over hospital care, but still have difficulty assuring payment for care provided at home.

Randy Kramer, a 25 year-old young woman from Miami, has cystic fibrosis and must travel long distances to receive daily therapy at a hospital. But even though her therapy could be provided more safely at home, and at significantly less cost, Medicare will not pay for her therapy at home. The Administration's restrictive definition of "homebound" under Medicare has placed not only elderly, but also chronically ill and disabled youth like Randy in situations which can be activity-limiting, sometimes life-threatening and often absorbing more public dollars than necessary.

Annie Bachschmidt from Washington, D.C. has a four-year old son with muscular dystrophy. Because payment for home care was so difficult to obtain, Robert stayed in Children's Hospital for 18 months at a cost of $865,800. Home care for the same period could have been provided at one tenth of the cost.

We heard many similar stories of the illogical and expensive regulations precluding payment for home health care. I would like to submit for the record a summary of the Select Committee's hearing on "Catastrophic Health Insurance: The Needs of Children," and a fact sheet prepared for that hearing so that you may have a record of our findings.

In addition, what became painfully clear is that the chronic illness or disability of a child spills over to other members of the family. As a result, these families make constant efforts to hold the family together, and to deal with the natural stresses and strains of marital relationships and relationships among their children. Yet our current policies deny these families both the financial support they need and other supports - such as respite care and attendant care - which would help them maintain basic family stability.

The Subcommittee is to be commended for the important steps you have already taken to improve catastrophic health coverage for the nation's elderly. I urge you to give serious consideration to policies which will protect children in the event of a catastrophic illness, and low-income children from the catastrophe which occurs when more routine care is unaffordable.

ONE HUNDRED FOURTH CONGRESS
GEORGE MILLER, CALIFORNIA
WILLIAM LEHMAN, FLORIDA
PATRICIA SCHROEDER, COLORADO
LINDY (MRS. HALE) BOGGS, LOUISIANA
MATTHEW F. MCHUGH, NEW YORK
TED WEISS, NEW YORK
BERYL ANTHONY, JR., ARKANSAS
BARBARA BOXER, CALIFORNIA
BARBARA B. KENNELLY, CONNECTICUT
BRUCE A. MORRISON, CONNECTICUT
J. ROY ROWLAND, GEORGIA
GERRY SIKORSKI, MINNESOTA
ALAN WHEAT, MISSOURI
MATTHEW G. MARTINEZ, CALIFORNIA
LANE EVANS, ILLINOIS
RICHARD J. DURBIN, ILLINOIS
THOMAS C. SAWYER, OHIO
DAVID E. SKAGGS, COLORADO
ANN ROSEWATER
STAFF DIRECTOR
TELEPHONE 226-7680

BARBARA F. VUCANOVICH, NEVADA
JACK F. KEMP, NEW YORK
GEORGE C. WORTLEY, NEW YORK
RON PACKARD, CALIFORNIA
BEAU BOULTER, TEXAS
J. DENNIS HASTERT, ILLINOIS
CLYDE C. HOLLOWAY, LOUISIANA
FRED GRANDY, IOWA
MARK SOUDER
MINORITY STAFF DIRECTOR
CAROL M. STATUTO
MINORITY HEALTH STAFF DIRECTOR
TELEPHONE 226-7892

U.S. House of Representatives

SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 House Office Building Annex 2
Washington, DC 20515

JOINT HEARING SUMMARY

"CATASTROPHIC HEALTH INSURANCE: THE NEEDS OF CHILDREN"
Washington, D.C., March 23, 1987

The Select Committee on Children, Youth, and Families held a joint hearing with the Select Committee on Aging, Subcommittee on Health and Long-term Care, to explore the catastrophic health needs of America's children. The hearing examined catastrophic and long-term health care needs of children, including new findings on the cost of medical and home health care and the availability of insurance.

Susan Sullivan, actor, from Los Angeles, CA; and member, Board of Trustees and spokesperson for the Foundation for Hospice and Home Care, Washington, DC, testified that the cost of home care for chronically ill children is about one fourth that of institutional care. Ms. Sullivan stressed that long-term care must be part of a coordinated effort that is flexible enough to adapt to each family's situation and comprehensive enough to provide home care for children with catastrophic illnesses.

Randy Kramer, age 25, from Miami, FL, with cystic fibrosis, spoke of her difficulties in obtaining home care benefits from her private insurance company, and since age 22, from Medicare. Randy stated that Medicare will not pay for her therapy at home because she does not meet the criteria for being homebound. The annual cost of her health care is $100,000, an amount which could be substantially reduced if Medicare reimbursed care provided at home.

Angie Bachschmidt, Washington, DC, spoke of the ventilator care needed by her 4 year old son, Robert, who has muscular dystrophy. Because payment for home care was so difficult to obtain, Robert stayed for 18 months in Children's Hospital at a cost of $865,800. Home care for the same period could have been provided for $90,000, one-tenth of the cost. Since January, 1985, Robert has lived at home, and his medical care has been paid by Medicaid. However, Bachschmidt stated that Robert's need for physical, occupational and speech therapy remains unmet because these services are not covered by Medicaid or CHAMPUS, for which he is also eligible due to his parents' military affiliation.

Mr. and Mrs. Tracy Sutton, parents of Alex Sutton, age 3, with Tay-Sachs disease, from Phoenix, AZ, testified about Alex's degenerative, terminal illness which requires a complicated regimen of medications and care. After a long battle with their private insurance company to cover Alex's home care, they secured coverage of 80% of the $200,000-250,000 in annual costs; the remaining 20% that the family must pay is still burdensome. Alex's father stated that dealing with catastrophic illness, such as Tay-Sachs, is emotionally stressful for families, and called for a policy to ease families' financial burdens.

Sandy Reckeweg parent of Jeffrey, age 5, from Clinton, MD, also testified. Jeffrey has Ondines, a breathing disorder. Reckeweg stated that most of Jeffrey's life was spent in the hospital until provisions could be made to use a respirator at home. She also testified that Jeffrey's care cost $600,000 a year for hospital care, and $150,000 for home care. Jeffrey's private insurance policy, which includes a cap of $100,000, was exhausted in less than 9 months; since then the family has incurred a debt of $800,000. Reckeweg said that because technology is keeping many children alive, society owes them a catastrophic health care program which will give children the right to be cared for at home.

Joe Miller, age 18, from Los Angeles, CA, became paralyzed after a bicycle accident in 1985. Since he was discharged after a 7 month hospital stay, his medical benefits have been limited. While his parents' employer-based insurance covered much of his medical care, Miller testified that his mother was forced to quit her job to care for him at home, and consequently her policy will soon lapse. Still, his home care costs $500 to $1000 a month compared to $18,000 per month in the hospital. He concluded that unless some change is made in government policy to help with the costs of catastrophic illness, he will have to face very high bills for the rest of his life.

Steven Brown, age 22, from Bethseda, MD, was accompanied by his mother Diane Fleming. Steven has Duchenne's muscular dystrophy, a disease that gradually weakens the body's muscles. He related that, when his condition became life-threatening in 1984, he chose to have a tracheostomy and to live with a ventilator in order to survive. He has been living at home for 2 1/2 years, at a cost of about $17,000 per month compared to $46,000 per month for hospitalization. Maryland Medicaid covers some of the expenses, as does the Muscular Dystrophy Association. Still many services are not covered, and the family has experienced a great deal of stress. Fleming closed her testimony by stating that, without comprehensive care, technology-dependent children do not experience the quality of life to which they are entitled and urged enactment of legislation to ensure that all children who need home care receive it.

Daniel Russell, age 4, of Kalamazoo, MI, was accompanied by his mother, Mrs. Scott Russell. Daniel, a premature infant, remained hospitalized after his birth with breathing problems caused by a weak congenital area in his trachea. A tracheostomy was performed to stabilize his breathing and at seven months of age he was discharged home. Hospital bills covered by insurance were $1,000 a day, totaling almost one-half million dollars by the time he was discharged. The cost of home care for Daniel is under $200 a day, but insurance covers only 75% of the cost. Russell concluded that leaving her child in a hospital, where the costs are reimbursed, or bringing him home, where out-of-pocket expenses are four times her income, is a choice most families of technology-dependent children could not afford to make.

Robert K. Massie Jr., age 30, from Boston, MA, has hemophilia. He described how the high cost of his care during childhood posed difficulties for his family who were in the military. During one tour of duty, the French National Health Insurance system relieved his family of health care costs for the first time. Due to recent scientific advancements, Massie now can self-administer anti-coagulant treatments at an annual cost of approximately $5,000. This home-based treatment allows him to lead a normal life, previously as a chaplain at Yale New Haven Hospital, and currently as an activist on behalf of chronically ill children.

Honorable Frank Moss, former U.S. Senator; and Chairman, Board of Trustees, Foundation for Hospice and Home Care, Washington, DC, testified that there are 10 to 12 million children who suffer with some degree of chronic health problem, with 2 million suffering severe chronic illness. Several million more children have experienced accidental injury. It is the evolution and refinement of technology which has made it possible for these children to be cared for at home, but according to Senator Moss, U.S. policy has not kept pace with technology. Many children are needlessly institutionalized. In conclusion, Senator Moss stated that there is universal agreement that the nation needs to enact a catastrophic health program, one that would address the major gap in long-term care for children.

Honorable Charles Percy, former U.S. Senator; and Vice Chairman, Board of Trustees, Foundation for Hospice and Home Care, Washington, DC, concurred that thousands of children remain in hospitals and other institutions because bureaucratic programs present barriers to home care. He shared the major findings of the Foundation's report, including that physicians generally agree that it is possible to manage the care of most chronically ill children at home, and agree on the criteria which must be met for hospital discharge; that most families do not abandon children born with anomalies and want them home; and that the major factor which stands in the way of bringing most children home is lack of funding. The Foundation's recommendations underscored the need to make changes in public and private funding sources to coordinate home care services for medically fragile children.

James Perrin, M.D., Director, Ambulatory Care Programs, Children's Service, Massachusetts General Hospital, Boston, testified on behalf of the American Academy of Pediatrics. Perrin reported that fewer than one million children (1% of all children under 21) are likely to incur catastrophic expenses, but families who experience a catastrophic illness--at birth, in childhood, and/or in adolescence--are often placed in extreme financial indebtedness. Perrin included recommendations to reduce the family's, provider's and insurer's risk in caring for children with catastrophic illness: state-mandated high risk pools, employee mandates covering prenatal and primary services for children, Medicaid expansions, and expanded Title V Maternal and Child Health-Crippled Children programs. Each option, he cautioned, has limitations and needs to be examined in light of children's unique needs.

In conclusion, Perrin said that children with long-term illnesses and their families need access to at least six major services: high quality medical and surgical speciality care; high quality general pediatric or general health services, including immunizations and health supervision; nursing services to help children stay at home, be at home, and to receive care primarily from their families; preventive mental health services; and social services and educational services so that these children can survive well with their classmates in school.

J.D. Northway, M.D., President and Chief Executive Officer, Valley Children's Hospital, Fresno, CA, testified on behalf of Western Association of Children's Hospitals. According to Northway, 19%, or 10.2 million, of this nation's children aged 0-16 have no health insurance at all, and many of these uninsured are children of the 'working poor.' He cited recent survey findings that many families do not have access to group health insurance because the employer does not offer it or the coverage is prohibitively expensive. Other children have pre-existing medical conditions, such as cancer or cystic fibrosis, which prevent them from obtaining private insurance coverage.

Northway reported new data from California on the cost of child hospitalizations. During 1984, there were 553,000 children age 0-14 hospitalized in California, excluding mental health admissions and Kaiser Hospital admissions. Only one-half of one percent incurred charges in excess of $50,000, for a total cost of $280 million or 22% of the total charges incurred by all 553,000 admissions. If the cost was spread out over the entire population ages 0-14, the cost would be $4.55 per child per month, less than one-third the cost of providing one day of public school instruction for one child in California. To the extent that public resources fall short, Northway reported, the burden of catastrophic costs falls on tertiary institutions such as childrens' hospitals and university medical centers.

Josephine Gittler, J.D., Co-Director, National Maternal and Child Health Resource Center, University of Iowa, Iowa City, concurred that a significant portion of the child population under 18 years of age lack private or public health insurance coverage for all or part of the year, and that in recent years a growing number of children have become underinsured. Her preliminary data shows that hospital care for technology dependent children costs $24,800 to $34,000 per month, compared to monthly home care costs ranging from $5,500 to $9,000. Gitler described a number of federal initiatives that could reduce insurance problems among children who have catastrophic health expenditures, including: establishment of a federal catastrophic health insurance program through the Title V Program for Children with Special Health Care Needs; expansion of Medicaid program eligibility; state options allowing uninsured or underinsured families to purchase Medicaid benefits with an income-adjusted premium; creation of state high-risk pools to enable uninsurable children to obtain comprehensive health insurance at reasonable prices; and finally, mandating or offering incentives to employers for the extension of minimum health care benefits to their employees and the dependents of their employees.

Sara Rosenbaum, Director, Child Health, Children's Defense Fund, Washington, DC, testified that in 1984, nearly one in five children, and one in every three poor children, was uninsured. The two main causes are: the major gaps in employer-based health insurance; and the failure of Medicaid to compensate for these gaps. She stated that it is essential to increase the percentage of children with health insurance and that any catastrophic policy approach for children must address both their relative and absolute catastrophic needs. For the immediate future, she recommended expanding Medicaid to reach more poor children who have no insurance and the development of a supplemental funding program to aid families whose children have catastrophic health needs.

Constance U. Battle, M.D., Medical Director and Chief Executive Officer, The Hospital for Sick Children, Washington, DC, spoke on behalf of National Association of Children's Hospitals and Related Institutions (NACHRI). She was accompanied by Robert H. Sweeney M.D., President, National Association of Children's Hospitals and Related Institutions, Alexandria, VA.

Sweeney presented findings from a recent NACHRI study of 85,000 admissions to children's hospitals nationwide. While only 1.35% of these admissions had charges over $50,000, they accounted for 26% of the total charges for the children's hospitals. Of these cases, 50% were newborns. Sweeney summarized four components of a comprehensive solution for children: require employers to provide minimum insurance which covers prenatal services and primary services for children, with insurance pools to assist small employers; facilitate individual choice of basic and catastrophic coverage through State risk pools

and tax incentives; mandate Medicaid coverage for pregnant women and children under age 6 who are below the federal poverty level, and standardize Medicaid coverage for mandated services; and include children and young adults in federal demonstration projects and studies of catastrophic insurance coverage.

Battle discussed the need for transitional care for infants from intensive care to their homes and communities. She presented case studies of children who survive today and are able to live with their families, but would not have in the past, illustrating clearly the changing technology and enhanced needs of a pediatric population in need of long-term. She concluded with the hope that creative and comprehensive programs can be developed to both care for these children and to provide stable financing for that care.

Michael Morris, Executive Director, United Cerebral Palsy Association, who testified on behalf of the Consortium for Citizens with Developmental Disabilities, Washington, DC, shared findings from a UCPA survey which showed that the average expenditure per year for special disability-related expenses, excluding surgeries, was $5,282 per family. To raise a child to the age of 18, the cost would be $95,083. If surgeries are included, the cost increases to $7,035 per year, or $126,631 to age 18. Morris noted that, of their survey respondents, only 1% were able to bear the additional expense of supporting a disabled family member without outside help. He stated finally, that appropriate coverage options for children and adults must be developed to stem the rising tide of individuals who find themselves medically uninsurable.

GEORGE MILLER, CALIFORNIA
WILLIAM LEHMAN, FLORIDA
PATRICIA SCHROEDER, COLORADO
LINDY (MRS. HALE) BOGGS, LOUISIANA
MATTHEW F. MCHUGH, NEW YORK
TED WEISS, NEW YORK
BERYL ANTHONY, JR., ARKANSAS
BARBARA BOXER, CALIFORNIA
BARNEY M. LEVIN, MICHIGAN
BRUCE A. MORRISON, CONNECTICUT
J. ROY ROWLAND, GEORGIA
GERRY SIKORSKI, MINNESOTA
ALAN WHEAT, MISSOURI
MATTHEW G. MARTINEZ, CALIFORNIA
LANE EVANS, ILLINOIS
RICHARD J. DURBIN, ILLINOIS
THOMAS C. SAWYER, OHIO
DAVID E. SKAGGS, COLORADO
ANN ROSEWATER
STAFF DIRECTOR
TELEPHONE: 226-7660

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 HOUSE OFFICE BUILDING ANNEX 2
WASHINGTON, DC 20515

DAN COATS, INDIANA
THOMAS J. BLILEY, JR., VIRGINIA
FRANK R. WOLF, VIRGINIA
NANCY L. JOHNSON, CONNECTICUT
BARBARA F. VUCANOVICH, NEVADA
JACK F. KEMP, NEW YORK
GEORGE C. WORTLEY, NEW YORK
BEN PACKARD, CALIFORNIA
BEAU BOULTER, TEXAS
J. DENNIS HASTERT, ILLINOIS
CLYDE C. HOLLOWAY, LOUISIANA
FRED GRANDY, IOWA
MARK SOLOMON
MINORITY STAFF DIRECTOR
CAROL M. STATUTO
MINORITY DEPUTY STAFF DIRECTOR
TELEPHONE: 226-7952

FACT SHEET
CATASTROPHIC ILLNESS AND LONG-TERM CARE:
ISSUES FOR CHILDREN AND FAMILIES

EXTENT OF CHRONIC ILLNESS AMONG CHILDREN

*Approximately ten million children (10-15% of all children) have a chronic illness; about one million have a severe chronic illness. (Gortmaker and Sappenfield, 1984)

*Between 1960 and 1981, the prevalence of activity-limiting chronic conditions among children under age 17 doubled, from 1.8% to 3.8%. Respiratory conditions and mental and nervous system disorders demonstrated the largest changes. (Newacheck, Budetti, and Halfon, 1986)

*Prematurity is anticipated in 6 births per 1000; cystic fibrosis in 1 birth per 1000; congenital heart disease in 7.5 births; and a diagnosis of cancer in 130 children per 1 million. (National Association of Children's Hospitals and Related Institutions [NACHRI], 1986.)

*Prevalence rates of certain diagnostic groups may have increased as a result of improved chances for survival. The evidence suggests a sevenfold increase in survival to age twenty-one among children with cystic fibrosis, and increases of twofold or greater for children with spina bifida, leukemia, and congenital heart disease. In 1984, the survival rate for childhood cancer was over 54%, compared to 39% in 1970. (Gortmaker, 1985; American Cancer Society, 1984)

*Poor children are 40% more likely to have a severe functional disability than do children in families with higher incomes (8.5% vs. 4.9%). (NACHRI, 1986)

CHRONICALLY ILL CHILDREN HAVE HIGH MEDICAL COSTS

*The cost of care for very distressed, ventilator dependent infants who remain hospitalized can reach $350,000 per year. (NACHRI, 1986)

*The annual expenses for hospital and physician services for a child with a disabling chronic condition has been estimated to range from $870 to $10,229, depending on the severity of the illness. In contrast, the typical healthy child's expenses for these services average about $270 a year. (Fox, 1984)

*In 1980, more than $1.7 billion were expended for physician visits and hospitalization of children with activity limitations; hospitalization accounted for 65% of the total. The average annual hospital cost for a child with activity limitation was $511 compared with only $66 for a child without limitations. (Butler, et al, 1985)

*Comprehensive care for a child with cystic fibrosis can cost a family $6,000-12,000 annually; and intermittent hospitalizations may average over $7,000 per stay. (NACHRI, 1987)

*Expenses for a child with cerebral palsy, including physician services, speech therapy, medications, special education, and other support services average $4490 annually, with 51% paid by the family. (United Cerebral Palsy Association, 1986)

ACUTE OR PRIMARY HEALTH CARE COSTS FOR CHILDREN HIGH

*In 1985, newborn intensive care costs totaled $2.4-$3.3 billion and averaged $14,698 for each infant. (American Academy of Pediatrics [AAP], 1986)

*Cardiac surgery for a child may cost a family $22,000 for a hospital stay. (NACHRI, 1987)

*Treatment for extensive burns may result in a hospital bill of $45,000. (NACHRI, 1987)

*The $600 cost of treatment for one asthma episode, or a routine hospitalization costing $700 per day, may be catastrophic for those with no insurance or very limited resources. (NACHRI, 1987)

SMALL PERCENTAGE OF CHRONICALLY ILL CHILDREN INCUR HIGH PERCENTAGE OF MEDICAL EXPENSES

*Fewer than 1 million or 1% of all children under 21 are likely to incur catastrophic expenses if catastrophic is defined as out-of-pocket medical expenses greater than 10% of family income. (AAP, 1986; Newacheck, 1986)

*About 5% of all children incur annual medical costs in excess of $5,000. Others estimate that 5-10% of children incur catastrophic expenses in excess of $10,000 (regardless of insurance coverage). (Rosenbaum, 1987; AAP, 1987)

*In 1983-84, the 1.35% of admissions to children's hospitals incurring catastrophic expenses over $50,000 accounted for 26% of the total children's hospitals' inpatient charges. Newborns accounted for 50% of these hospital admissions. (NACHRI, 1987)

*In 1980, the total cost for hospitalization of children with activity limitations ($1.17 billion) was 30% of the total hospital care costs ($3.86 billion) for all children. (Butler, 1985)

MILLIONS OF CHILDREN WITH NO HEALTH INSURANCE

*In 1985, 11 million children age 18 or younger were uninsured. Among uninsured children, 64% lived in families headed by someone without health insurance; 29% lived in families headed by someone with employer-based health coverage, usually a parent. (Employee Benefits Research Institute [EBRI], 1987)

*Three-quarters of all uninsured children have family incomes below 200% of the federal poverty level, and between 66-75% live in working families. (Rosenbaum, 1987)

*In 1985, nearly half of the uninsured children age 18 or under lived in single-parent, usually female-headed, families. (EBRI, 1987)

*Children without any form of health insurance protection were most likely to be Hispanics and near poor children whose family incomes were between 100 and 200% of poverty. Children living in the South and West and in the rural areas were more likely than those in other regions and communities to lack coverage. (Butler, 1985)

*10.3% of disabled children, and 19.5% of disabled children in poverty have no health insurance. (Butler, 1985)

*Forty percent of all disabled children below the federal poverty level are not covered by Medicaid. Private group and individual insurance covers about 60% of disabled children, compared to 75% in the general child population. (Butler, 1985)

*In FY 1985, Medicaid served 10.9 million children younger than 21 -- more than 400,000 fewer than were served in FY 1978. (Rosenbaum, 1987)

*Uninsured low-income children receive 40% less physician care and half as much hospital care as insured children. (Rosenbaum, 1987)

MILLIONS OF CHILDREN WITH INADEQUATE INSURANCE

*Of those children under 18 who are insured, 17% do not have major medical to cover special health care costs, and less than 10% have unlimited coverage. (NACHRI, 1987)

*Of all employers responding to a major health insurance survey conducted in 1986, 73% indicated that their plans excluded coverage of pre-existing conditions. Only about 75% of plans offered by medium and large-sized firms between 1980 and 1985 contained protections against huge out-of-pocket costs borne by enrollees in the event of catastrophic illness. (Rosenbaum, 1987)

*Fourteen state Medicaid programs limit the number of hospital days covered each year, and 15 states restrict the number of covered physician visits. (Rosenbaum, 1987; Fox, 1984)

○